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ABSTRACT

For organizations providing support to mental health consumers, "cultural competency," or the ability to reach out effectively and appropriately to individuals of different cultural backgrounds, is central to meeting the needs of a diverse community. The Cultural Competency Initiative, which was launched in the year 2000, assisted consumer supporter organizations by providing funding and technical assistance as well as by disseminating information about innovative minority outreach programs. Each chapter of this toolkit provides an overview of one of ten model programs. Project goals and implementation plans are shared, project leaders share their expertise, and program materials are included in each chapter's appendices. The National Consumer Supporter Technical Assistance Center hopes that this information will assist other consumer supporter organizations in their efforts to launch similar outreach programs. (GCP)

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A Cultural Competency Toolkit:

Ten Grant Sites Share Lessons Learned

National Consumer Supporter Technical Assistance Center
National Mental Health Association

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Community Support Program Branch

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The National Consumer Supporter Technical Assistance Center (NCSTAC) is funded by the Center for Mental Health Services and run by the National Mental Health Association. NCSTAC provides assistance to mental health consumer supporter organizations across the country in the forms of educational manuals and fact sheets, trainings, and ad hoc technical assistance.

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Key concepts: African Americans, community assessment, the elderly, Hispanic/Latino Americans, manual writing

Chapter 3: Georgia 3.1

Key concepts: African Americans, depression, education of professionals, public education, rural communities

Chapter 4: Hawaii 4.1

Key concepts: advocacy, Asian Americans, consumer involvement, leadership/advocacy training, Native Hawaiians, public education, speakers' bureau

Chapter 5: New Mexico 5.1

Key concepts: consumer involvement, Hispanic/Latino Americans, leadership/advocacy training, Native Americans, rural communities

Chapter 6: Philadelphia, Pennsylvania 6.1

Key concepts: advocacy, consumer involvement, the elderly, leadership/advocacy training, public education

Chapter 7: South Carolina 7.1

Key concepts: African Americans, community assessment, the elderly, event planning, public education, rural communities

Chapter 8: Texas 8.1

Key concepts: Asian Americans, assessment of professionals' cultural competency, education of professionals

Chapter 9: Utah 9.1

Key concepts: African Americans, Asian Americans, Deaf culture, education of professionals, Hispanic/Latino Americans, interpreters, Native Americans, Pacific Islanders

Chapter 10: Washington 10.1

Key concepts: Asian Americans, consumer involvement, Hispanic/Latino Americans, Russian Americans, translation, warm-line implementation

Introduction: The Cultural Competency Initiative

For organizations providing support to mental health consumers, "cultural competency"— the ability to reach out effectively and appropriately to individuals of different cultural backgrounds — is central to meeting the needs of a diverse community. Recent U.S. census data indicate that nearly 70 million Americans are people of color and that this number is growing. This shift in the U.S. population has a significant impact on the mental health services system. According to the U.S. Surgeon General, language differences, cultural barriers and stigma prevent people of color from receiving necessary or adequate services.

The National Consumer Supporter Technical Assistance Center (NCSTAC) is in a unique position to play a pivotal role in this area. NCSTAC, through its Cultural Competency Initiative, has attempted to increase understanding of ethnic and racial disparities in mental health treatment and to support efforts that address the related barriers to adequate treatment.

The Cultural Competency Initiative, which was launched in 2000, assisted consumer supporter organizations by providing funding and technical assistance as well as by disseminating information about innovative minority outreach programs.

The Cultural Competency Initiative provided funding and disseminated information about innovative programs of minority outreach.

Through a competitive selection process, ten sites across the country were each awarded $5,000 to launch new initiatives or to build upon existing programs over a one-year period. Sites chosen already had proven track records in reaching out to special populations.

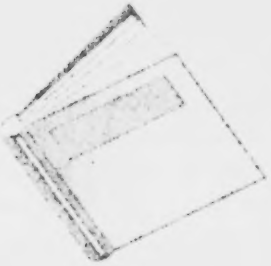
The sites that were selected began to address the issues of cultural competency in their communities and to document the lessons learned in carrying out these efforts. With data from these ten organizations, NCSTAC is now able to offer this Cultural Competency Toolkit. Each chapter provides an overview of one of the ten model programs. Project goals and implementation plans are shared, project leaders share their expertise, and program materials are included in each chapter's appendices. NCSTAC hopes that this information will assist other consumer supporter organizations in their efforts to launch similar outreach programs.

NCSTAC's vision is of a just, humane and healthy society in which all people are accorded respect, dignity and the opportunity to achieve their full potential free from stigma and prejudice. It is our hope that organizations providing support to mental health consumers can help to make this vision a reality one project at a time.

Language differences, cultural barriers and stigma continue to prevent many individuals from receiving necessary or adequate services.

Overview of chapters

Chapter one discusses the Mental Health Association in Alaska's (MHAA's) Mentor Project. With NCSTAC funding, MHAA flew five Native Alaskans from the state's most remote regions to Juneau to attend a three-day leadership training to develop advocacy skills.



Prior to this grant proposal, the Mental Health Association of Allegheny County (MHAAC) participated as a founding member in a local Multicultural Outreach and Education Task Force. MHAAC believed that this massive outreach effort was highly replicable, and **chapter two** discusses how this organization used NCSTAC funding to prepare and disseminate a how-to manual for replicating their project.

Chapter three provides an overview of the National Mental Health Association of Georgia's Project HOPE, (Healing, Opportunity, Prevention and Education). Project HOPE aimed to increase awareness in Georgia's African American community of the symptoms of and treatments for depression.

Chapter four describes how the Mental Health Association in Hawaii (MHAH) used its NCSTAC funding to strengthen its existing speakers bureau by recruiting and training mental health consumers of different cultural backgrounds. Over the course of this project, MHAH enlisted eight Native Hawaiians and Asian Americans as consumer advocates.

Chapter five discuses NAMI-New Mexico's (NAMI-NM's) Consumer Involvement Project. NAMI-NM offered a series of workshops at seven different locations across the state to help consumers to launch their own self-help and advocacy programs.

Chapter six explains how the Mental Health Association of South Eastern Pennsylvania (MHASP) built upon its existing Mental Health/Aging Advocacy Project. MHASP trained elderly consumers and their caregivers to advocate for the mental health needs of older Americans in the Philadelphia area.

Aiken County, South Carolina is rated as one of the top 100 places to retire in the United States and accordingly has a large population of older Americans. **Chapter seven** provides an overview of the Mental Health Association in Aiken County's efforts to found an Elder's Task Force to help serve this population's needs.

Despite stereotypes to the contrary, mental illnesses among Asian Americans are actually common. **Chapter eight** describes how Houston's Asian American Family Counseling Center designed and offered a series of brown bag lunches where local mental health professionals could learn more about working with the area's Asian American communities.

Chapter nine explains how the Mental Health Association in Utah organized a two-day conference where 200 mental health professionals could learn about cultural competency. Conference workshops explored working with Utah's various minority populations: Native Americans, Latinos, African Americans, Pacific Islanders and Asian Americans. Additionally, one workshop focused on Deaf culture.

Consumer Voices Are Born (CVAB), a consumer-run drop-in center, established a warm-line where individuals in the Clark County, Washington area facing mental health challenges could call in and discuss their problems with a peer. **Chapter ten** focuses on CVAB's efforts to extend warm-line services to the county's various ethnic communities.

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Cultural Competency Toolkit

CHAPTER 1

The Mentor Project: Fostering Consumer Advocacy Among Native Alaskans

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Jan McGillivary, Project Director

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Executive Summary

The Native population in Alaska experiences high instances of substance abuse and violence and utilizes the state mental health system at a much higher rate than Caucasians. At the same time, there are few Native Alaskan consumers involved in mental health advocacy work. In part, this is due to the remoteness of many Native Alaskan villages, which precludes networking with other consumer groups and consumer leaders. Through the Mentor Project, the Mental Health Association in Alaska (MHAA) proposed to sponsor five Native Alaskans living in remote regions to attend the Bridges 2000 Fly-In. At the Bridges Fly-In, an annual gathering for consumer leaders spearheaded by MHAA, these individuals would have the opportunity to learn about self-advocacy and consumer advocacy skills.

Project Goals

- To involve five Native Alaskans in the Bridges 2000 Fly-In.
- To thereby encourage advocacy among Alaska's native population.

Introduction

There are twelve major native tribes in Alaska, who make up approximately one quarter of the state's population of 600,000 people. Proportionally, the Native Alaskan population utilizes the state mental health system at a much higher rate than Caucasians, with the preponderance of substance abuse, interpersonal violence, sexual abuse and suicide among Native Alaskans having severe, multi-layered social and economic implications for this community.

The preponderance of substance abuse, interpersonal violence, sexual abuse and suicide among Native Alaskans has severe, multi-layered social and economic implications for this community.

Yet the consumer empowerment movement in Alaska sadly lacks Native influence. For example, the Building Bridges Campaign for Mental Health, an initiative aimed at fostering leadership and advocacy skills among Alaskan consumers of mental health services, has involved some 250 consumers and family members since its inception in 1994. Yet of that number, only five Native Alaskans at the time of this proposal had had the opportunity to participate in the program.

Contributing to the lack of involvement by Native Alaskans is the state's expansive, arctic geography and very sparsely developed road system. Many Native Alaskans live in remote areas sometimes accessible only by air.

Program Plan

At the time of this proposal, MHAA had been successfully spearheading the Bridges Fly-In for six years, working with other mental health organizations to organize an annual three-day event providing training in leadership and advocacy skills to mental health consumers, their friends and family members. While MHAA handled primary oversight and coordination for this Fly-In, the Alaska Community Mental Health Services Association provided funding.

Through the Mentor Project, MHAA proposed to sponsor five Native Alaskan consumers to take part in the Bridges Fly-In. These new consumer leaders would be flown to Juneau, would meet and learn the latest methods for impacting public policy, and would be given the opportunity to take part in advocacy activities.

Native Alaskans flew in from the state's most remote regions to participate in the Fly-In.

Organizational Overview

At the time of this proposal, MHAA had been an instrumental leader of the mental health movement in the State of Alaska for almost fifty years. To name a few of its activities, MHAA participated in the development of a state psychiatric hospital; of community mental health centers; of women's shelters, crisis centers, support groups and transitional living programs.

As the only broad-based organization in Alaska advocating for people with mental illness and for the prevention of mental and emotional illnesses, MHAA also monitored legislation and its potential for improvement. MHAA worked diligently towards the resolution of the Mental Health Trust Lands issue, pursuing a twelve-year legal struggle culminating in a new law establishing the Alaska Mental Health Board and a Mental Health Lands Trust Authority designed to protect these funds in perpetuity. MHAA was further involved in the process of negotiation with the State of Alaska over the value of the mental health lands.

MHAA participated in the development of a state psychiatric hospital; of community mental health centers; of women's shelters, crisis centers, support groups and transitional living programs.

MHAA was also an advocate for prevention programs and for a stronger focus on Alaskan youth. The organization advocated for expanded services for the mental health consumer in the form of pre and post hospitalization services, supported employment programs, group and individual sheltered housing projects, respite care programs, and efficient statewide crisis intervention services.

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Through an active and ongoing public education process, MHAA also attempted to counteract the stigma that often surrounds mental illness, taking part in the national Mental Health Month campaign in May and in Mental Illness Awareness Week activities in October.

Implementation

In order to contact Native Alaskans to take part in this initiative, project director, Jan McGillivary, networked with other Alaskan mental health organizations including National Alliance for the Mentally Ill, the Alaska Mental Health Board, and community mental health services associations. These various groups reached out to the Native Alaskan communities in their areas to find local consumers interested in participating.

Participants at the March, 2001 Bridges Campaign Fly-In.

The Fly-In took place March 20 through March 22 in the state capitol, Juneau, and five Native Alaskans, sponsored by the Mentor Project, participated. The Fly-In's training agenda included special meetings with mentors, a workshop on how to serve on a board of directors, and a detailed overview of the state government offices. In addition, visits to state legislators, a public hearing before the state senate and a meeting with the governor were also scheduled.

Discussion, Conclusion

Although one-quarter of Alaska's population is made up of Native peoples, McGillivary reports that the state's policy makers are still almost entirely Caucasians: "If you go to the state legislature or any urban community where there's policy-making taking place, you will rarely see a native face."

McGillivary describes it as "her personal mission over the past sixteen years" to attempt to rectify this inequity. She readily acknowledges that as a white person, this is not always easy to do. As with any other cultural group, Native Alaskans tend to be more trusting of individuals from their own communities. "Entering that circle (of the Native Alaskan community) is not always a clear-cut path. It's often very oblique and subtle."

While policy-making occurs year-round, the Native Alaskan life-style still centers around seasonal activities such as hunting and fishing.

Besides the communication barriers that can always exist between individuals of different cultures, there are also other obstacles inherent in trying to invite Native Alaskans to participate in predominantly white mental health delivery systems and policy-making

structures. While policy-making occurs year-round, the Native Alaskan life-style still centers around seasonal activities such as hunting and fishing. During these time periods, fewer Native Alaskans are able to participate in advocacy activities.

Moreover, the pressures imposed by Alaska's harsh climate and sparse population cannot be underestimated. McGillivary describes most villages as "just a pocket full of people," and many village inhabitants may not even have telephones. Local mental health service organizations will serve perhaps ten or eleven villages spread over a wide area. Travel between villages is typically expensive and sometimes, due to extreme weather conditions, simply impossible.

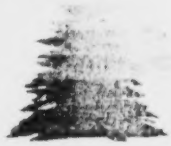
One project participant testified before the State Mental Health Commission. His testimony was so moving that he received a standing ovation.

Nonetheless, McGillivary believes that the Mentor Project and other similar outreach and advocacy training programs are beginning to bear fruit. She reports that "this year at Bridges there were more native faces than ever before. There was a substantial difference in the flavor of the event."

State mental health providers are also becoming more attuned to the importance of working cooperatively with their Native Alaskan constituency. A recent cooperative initiative is teaming the Native Alaskan Tribal Council with the public mental health system to utilize telecommunications to promote mental health.

And following the Fly-In, one project participant testified before the State Mental Health Commission. His testimony was so moving that he received a standing ovation, and shortly thereafter he was invited to apply to become a mental health commissioner.

Alaska's rural geography, with few roadways, makes it difficult for advocates to gather together.



Additional Resources

Publications

Herring, Roger. *Counseling With Native American Indians and Alaska Natives: Strategies for Helping Professionals*. Thousand Oaks, California: Sage Publications, c1999.

Native Outreach: A Report to American Indian, Alaska Native, and Native Hawaiian Communities. Bethesda, Maryland: National Institutes of Health and National Cancer Institute. 1999.

Trimble, Joseph and Bagwell, Weldon (editors). *North American Indians and Alaska Natives: Abstracts of the Psychological and Behavioral Literature, 1967-1994*. Washington, D.C.: American Psychological Association. 1995.

Organizations

Indian Health Service
Tel. (301) 443-3593
Website: www.ihs.gov

Office of Minority Health
Department of Health and Human Resources
Tel. (800) 444-6472
Email: info@omhrc.gov
Website: www.omhrc.gov

MISSION STATEMENT OF THE BUILDING BRIDGES CAMPAIGN FOR MENTAL HEALTH

Empower mental health consumers, their families, providers and advocates.

Turn awareness into action for Alaskans experiencing mentally illness.

Increase state funding for community based services and programs serving persons experiencing mental illnesses.

Facilitate a grass roots effort to positively affect the legislative and other public policy decision making processes.

Increase cohesiveness within Alaska's mental health community.

Advance principles of Life Domains and Mental Health Parity and coordinate with other advocacy efforts in Alaska.

Building Bridges Campaign for Mental Health
8th Annual Fly-In Agenda

March 19 - 20, 2001	**ACMHSA - Juneau**
Monday - March 19	
3:00 - 5:00 pm	Mentor Training - Goldbelt Hotel, Juneau
Tuesday - March 20	
10:00 - Noon	Pre-Conference Training at McPhetre's Hall "How to Serve on a Board of Director's"
1:00 - 5:00 pm	**8th Annual Building Bridges Campaign Opens at McPhetre's Hall, Juneau**

Wednesday - March 21

8:00 - 5:00 pm	McPhetre's Hall - Hill Visits All Day Long
11:00 am	Meeting with Governor Knowles - Governor's Conference Room, State Capitl
1:30 pm	HESS Committee Hearing

Thursday - March 22

7:30 am	Legislative Breakfast Reception - Baranof Hotel
9:00 am	Hill Visits All Day Long
Noon	JAMI's Green Doors Annual Consumer Luncheon
1:00 - 5:00 pm	Hill Visits
6:00 - 8:30 pm	Dinner at McPhetre's Hall - Closing

Alaska Mental Health Board

meets

Thursday - Saturday

March 22, 23 & 24

Alaska Mental Health Board

Location:
Alaska Office Building, Room 123
350 Main Street (4th & Main), Juneau

Convenes:
8:45 am Thursday, March 22

Adjourns:
5:15 pm Saturday, March 24

Why should I get involved?

Alaska has some of the highest rates of suicide, interpersonal and domestic violence, substance abuse, teen pregnancy and unemployment rates. Although these issues do not translate into diagnosable mental illnesses they do contribute to increasing demands on Alaska's mental health delivery system.

Alaska is characterized by a wide disparity in incomes with the highest concentration of millionaires in the nation, as well as, more than one in five people living below the poverty level. The unemployment rate is above the national average characterized by seasonal labor. Unemployment in rural areas varies dramatically from winter to summer and from one region to another. In the Interior, unemployment approaches 20% in the winter months.

Child abuse and neglect reports continue to occur at an alarming rate. The number of reports of child abuse and neglect in Alaska continue to increase past the rate of population growth.. Increases in the total number of reports have been accompanied by increases in the severity and complexity of these cases. Almost all of the families served by the Division of Family & Youth Services are families at high risk requiring more intense levels of contact and support. Over 1,300 children and youth are now in foster or residential care at any given point in time.

Widespread alcohol and drug abuse have a devastating impact on children, families and entire communities across Alaska. Data suggests that there may be more than 37,000 or approximately 1 in 16 Alaskans who experience alcohol problems.

As children comprise 30% of Alaska's total population, it is startling to note that 11% of Alaskan families are headed by one parent of which 20% are below the poverty line. Increases in the numbers of parents working outside the home and large increases over the generation in children living with only one parent have ongoing implications, especially since Alaskan birth and divorce rates continue to be among the highest in the nation.

In other words, Mental Health is Important to Everybody! Your decision to join the Building Bridges Campaign as an advocate for change can make a difference in the long run.

There is more in us than we know. If we can be made to see it, perhaps, for the rest of our lives, we will be unwilling to settle for less.

Kurt Hahn

Founder, Outward Bound

Your Vote Counts!

DON'T EVER THINK YOUR VOTE DOESN'T COUNT, BECAUSE IN...

1645 ONE vote gave Oliver Cromwell control of England.

1649 ONE vote caused Charles I of England to be executed.

1776 ONE vote gave America the English language instead of German.

1800 Thomas Jefferson was elected president by only ONE vote in the electoral collage over Aaron Burr.

1839 ONE vote elected Marcus Morton Governor of Massachusetts.

1845 ONE vote brought Texas into the Union.

1868 ONE vote saved President Andrew Johnson from impeachment.

1876 ONE vote gave Rutherford Hayes the Presidency of the United States and ...

ONE vote changed France from a monarchy to a republic.

1923 ONE vote gave Adolph Hitler leadership of the Nazi party.

1939 ONE vote passed the selective service act.

1948 ONE vote per precinct in California gave Harry Truman the presidency.

1960 ONE vote per precinct elected John F. Kennedy President of the U.S.

1978 In Fullerton, California a Democratic candidate for the State of California's legislature lost by TEN votes in a primary election where 32,000 votes were cast.

...AND IN ALASKA...

1978 Jay Hammond won the nomination for Governor over Walter Hickel in the Primary Election by just 98 votes statewide. That's less than 1/4 VOTE per precinct.

1978 ONE vote elected Tim Kelly to his Senate seat in District F.

1982 TWO votes gave the nomination for State Senator in District J to David McCracken in the Primary Election.

1984 ONE vote gave Mary Ratcliff the nomination for State Representative, House District 12 in the Primary Election.

1986 SEVENTEEN votes (less than ONE vote per precinct) elected Rick Uehling Senator for District H, Seat B, out of the 14,389 votes cast.

1988 SIX votes elected David Finkelstein to State Representative District 13, Seat A. Less than ONE vote per precinct.

1990 TEN votes elected Terry Martin to State Representative District 13, Seat B. Just ONE vote per precinct.

1990 Four contests in the General Election were decided by a margin of less than ONE PERCENT of the votes cast in each contest.

1992 FIVE votes gave Al. Vesey the nomination for State Representative, House District 32 in the Primary Election. Less than one vote per precinct.

1993 FIVE votes put Charles Wohlforth on the Anchorage Municipal Assembly, beating out Gloria Shriver. They were the top two of seven candidates for that seat. 32 votes decided another race in that election, putting Cheryl Clementson on the Assembly instead of Eddie Burke.

1994 1.1 votes per precinct Elected Tony Knows as Governor and Fran Ulmer as Lt. Governor, out of 216,668 votes cast.

1996 ONE vote gave Anne Sponholtz the Democratic nomination for the Senate.

Golden Rules

(For everyone who works with public officials)

Have you ever presented your case, or your cause, to a public official? If so, you will recognize these universal principles that apply across the board for everyone who works with legislators, commissioners, city councilmen and other public officials.

* **Don't underestimate public officials.** With very rare exceptions, they will be honest, intelligent and will want to do the right thing. Your job is to inform them what YOU think is right.
* **Don't look down on government and policies.** They may be faulty, but so are other professions. A disdainful attitude is an expensive luxury these days. Whatever affects your business...IS...your business...even if it is politics.
* **Be understanding.** Put yourself in the public official's place. Try to understand the official's problems, the official's outlook, the official's aims. Then you are more likely to persuade the official to do the same in understanding yours. Remember that we must have people who are willing to commit themselves to public service positions.
* **Be friendly.** Don't contact public officials only when you want their help. Invite them to be guests at meetings. Take pains to keep in contact with them throughout the year, every year.
* **Be informed.** Never meet with public officials to advocate a position without first studying the facts and the arguments pro and con. The mere fact that you want a public official to adopt one position or another won't be enough to convince the official. Do your homework.
* **Be reasonable.** Recognize that there are legitimate differences of opinion, with at least two sides to every issue. Never indulge in threats or recriminations. They are confessions to weakness.
* **Be thoughtful.** Commend the right things public officials do. That's the way you like to be treated. Any public official will tell you that he gets dozens of letters asking him to do something, but very few thanking him for what he has done.
* **Don't blame public officials for "failing" to do what you wanted.** Choices are not always clear cut, and the failure could be yours if you have not done a good job in preparing, presenting and following through on your case.

- **Don't be a busybody.** You don't like to be scolded, pestered or preached to. Neither do public officials.
- **Be cooperative.** If a public official makes a reasonable request of you, try to comply with it. Don't back away for fear that it's a "deal," or that you're "getting into politics."
- **Be realistic.** Remember that controversial legislation and regulation usually result in compromise. It has always been so and it will always be so in a democracy.
- **Be open and candid.** State your views, and the reasons for your position, with willingness to listen to the problems and concerns that your position may create for the public official.
- **Be practical.** Recognize that each legislator has commitments and that a certain amount of vote-trading goes on in a legislature. Don't chastise a legislator who normally supports you if he happens to vote against one of your bills. This doesn't necessarily mean he has deserted your whole program. Give the legislator the benefit of the doubt: the legislator will appreciate it and remember that you did. There will be other "roll calls" and the next time the legislator may vote for you. Also, remember that while some votes may be firmly committed, there will be many others that can be swayed on the basis of sound arguments, properly presented.
- **Be a good opponent.** Fight issues — not personalities. And be ready with alternatives or solutions as well as with criticisms. This is constructive opposition.
- **Never break a promise.** This is a cardinal rule of politics. If you tell a public official you'll do something in exchange for a certain action, stick to the bargain. Politics, and politicians, work on a base of mutual trust and confidence.
- **Don't change horses in the middle of the stream.** Never leave an official stranded out on a limb by changing your policy or position after the official has publicly stated a position that you have urged him to take.
- **Learn to evaluate and weigh issues.** Many bills which are tossed into the hopper "by request" are never intended to become law. So, don't criticize legislators for the bills which are introduced, and don't call out the army until you're sure a bill is serious.

More on how to Advocate Effectively

Contrary to the perception of many people, advocating effectively is **not** for experts only. Advocating can be easy, stimulating, and fun. All you need to be an effective advocate are three things:

1. A Few Basic Facts

* What is the substance of the legislation you are proposing or opposing?
* Why is it so important?
* What will happen if it passes (or does not pass)?
* How much will it cost?

The Building Bridges Campaign will provide you with facts, figures and current information on the issues affecting the mental health budget and other issues such as health care reform in Alaska.

2. Belief in the Cause of Improved Mental Health Services

If you have conviction, dedication to the unmet needs of the mentally ill and emotionally disturbed, and determination to see the needs met no matter how long it takes, then you will be an effective advocate.

3. A Little Common Sense

Whether advocating face-to-face, by letter, by telephone or through a Public Opinion Message (POM), an effective advocate follows these common sense principles:

DO -

* Be brief
* Be prepared
* Be clear
* Be honest
* Be accurate
* Be persuasive
* Be timely
* Be persistent
* Be grateful.

DO NOT -

* Be argumentative
* Promise rewards
* Be demanding
* Knock the opposition
* Bluff.

Be so good they can't ignore you.
Steve Martin

Public Speaking and Testimony

Public Speaking, at a hearing for example, is an opportunity to influence many people at once. Remember reading a prepared statement is much better than forgetting your ideas because you tried to be spontaneous.

The Bridges group will arrive at a consensus as to which members will act as spokespeople. Sometimes it's appropriate for more than one to speak, but others should be enlisted as backup speakers. This comes in particularly handy at meetings where each participant is allowed only one turn, and your position needs to be clarified later in the proceedings. *Never* sign up to speak at a public hearing or conference without one alternate, and preferably two in reserve.

Bridges will rehearse testimony before meeting with the Legislative Committees.

Like your letters, or one-to-one discussions, your statements should be courteous, brief and to the point:

> Good afternoon. My name is _____ and I am a resident of _____. I'm here today on behalf of the **Building Bridges Campaign for Mental Health** to request that you maintain funding for our community based mental health services. This issue affects approximately one of four individuals in Alaska.
>
> End your story with, "Thank you for giving me the opportunity to speak, and I will try to answer any questions you may have."

Remember, written testimony will also be collected and distributed. So please prepare your testimony in advance.

Telephone Calls to Legislators

Telephone calls can be an effective means of communicating with legislators if the calls:

(1) convey a meaningful message with helpful information, and

(2) are made in a timely manner.

Calls from constituents are the most effective; "telephone blitzes" are the least effective. Other calls are somewhere in between.

It is important to remember that, during the legislative session, legislators usually are attending committee meetings, conducting other legislative business such as meeting with staff, drafting legislation, preparing for bill presentations, lobbying other legislators, or participating in formal legislative work in the Senate or House chambers. Therefore, it is likely that a legislator will not be available to take your call. If that is the case, do not hesitate to leave your message with a legislative assistant or other staff. Trust the staff to get your message to the legislator.

If you request a return call, you can usually be assured of getting one if you are a constituent. Others may get a return call. Remember that there simply are not enough hours in the day for legislators to return all calls, particularly if there is an organized blitz underway. Fortunately, most people are comfortable leaving their message with staff.

It is important to make your call brief and to the point. Always be polite.

In conveying your message, do the following:

* Identify yourself with your name and your city or town of residence.
* If your call is regarding a specific bill, give the bill number and subject matter.
* State your support (or opposition) to the bill and a brief reason for your position
* Request the legislator's support (or opposition) to the bill.
* Indicate your availability to discuss the issue further, if desired.
* Leave your telephone number.
* Express thanks.

Your call will have the most impact when received within a week of the bill's being heard in committee. If the legislator serves on the committee hearing the bill, that is a bonus! Another appropriate time, but usually not nearly as effective, is shortly before the bill is heard by the entire legislative body.

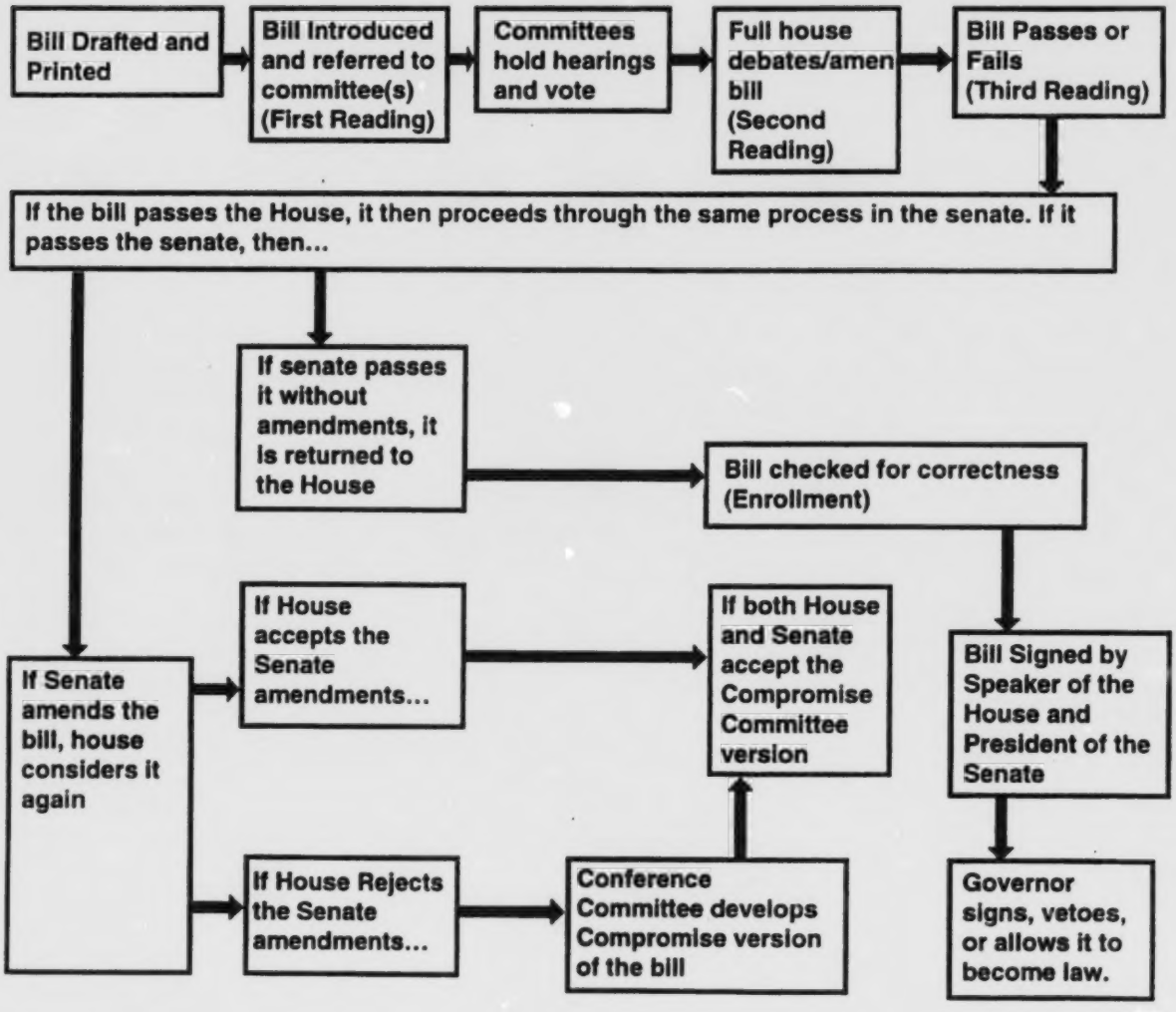
Legislators also receive many calls from people requesting assistance for a problem with the bureaucracy. These calls are handled in the same manner in which letters requesting assistance are handled.

A Candle loses nothing by lighting another candle.

Father James Keller

Steps in the Passage of a House Bill

This chart shows the process of a House Bill. For a Senate Bill, the process is identical, except that it starts in the Senate and is sent to the House. This chart shows the procedures for the Alaska State Legislature.


Bill Drafted and Printed
Bill Introduced and referred to committee(s) (First Reading)
Committees hold hearings and vote
Full house debates/amen bill (Second Reading)
Bill Passes or Fails (Third Reading)
If the bill passes the House, it then proceeds through the same process in the senate. If it passes the senate, then...
If senate passes it without amendments, it is returned to the House
Bill checked for correctness (Enrollment)
Bill Signed by Speaker of the House and President of the Senate
Governor signs, vetoes, or allows it to become law.
If both House and Senate accept the Compromise Committee version
If House accepts the Senate amendments...
If Senate amends the bill, house considers it again
If House Rejects the Senate amendments...
Conference Committee develops Compromise version of the bill

THE TELEPHONE TREE

Many of us are tired of feeling isolated and uninformed about issues that are important to Alaskans with mental illness and their families. Consider starting a telephone tree as a step toward bringing people with similar concerns together to advocate for increased funding for services.

Alaskans with mental illness face a crisis. Despite increasing dollars being deposited into the Mental Health Trust Income Account, funding for mental health services is declining. Services have been cut and waiting lists grow. Our only power lies in our ability to unite and let out legislators know that we will not allow them to cut programs that provide valuable services to people.

HOW THE TREE WILL WORK

Designate a telephone tree coordinator in each organization. Their job will be to see that everyone in the tree receives the necessary information to make informed decisions and that the tree is properly organized. In addition, the coordinator will activate the tree when issues needing action are brought to its attention.

The tree becomes activated when the coordinator learns that action is needed on some issue. Each member of the tree will then call three people assigned to them and inform them about the situation and the action needed. Each of those three people will in turn call three other people and tell them what is happening. This way, each of us only has to call three others but many people will eventually be reached.

WHAT YOU AGREE TO DO AS A TREE MEMBER

We realize that most of us work and are busy with our families leaving very little time for other activities. We have tried to set the tree up so that each of us can fulfill our part in one hour or less each time the tree is activated. As a member of the tree you must be willing to:

1. Call the three people assigned to you or follow through with the action requested. While you will not always be able to reach everyone, keep in mind that each person has three others to call in turn. You will contact the tree coordinator if you are unable to reach a person on your "line."
2. At your option, take some appropriate action. You may choose to meet with your legislators, write a letter, make a phone call or take some other action. There may be other times when you choose to

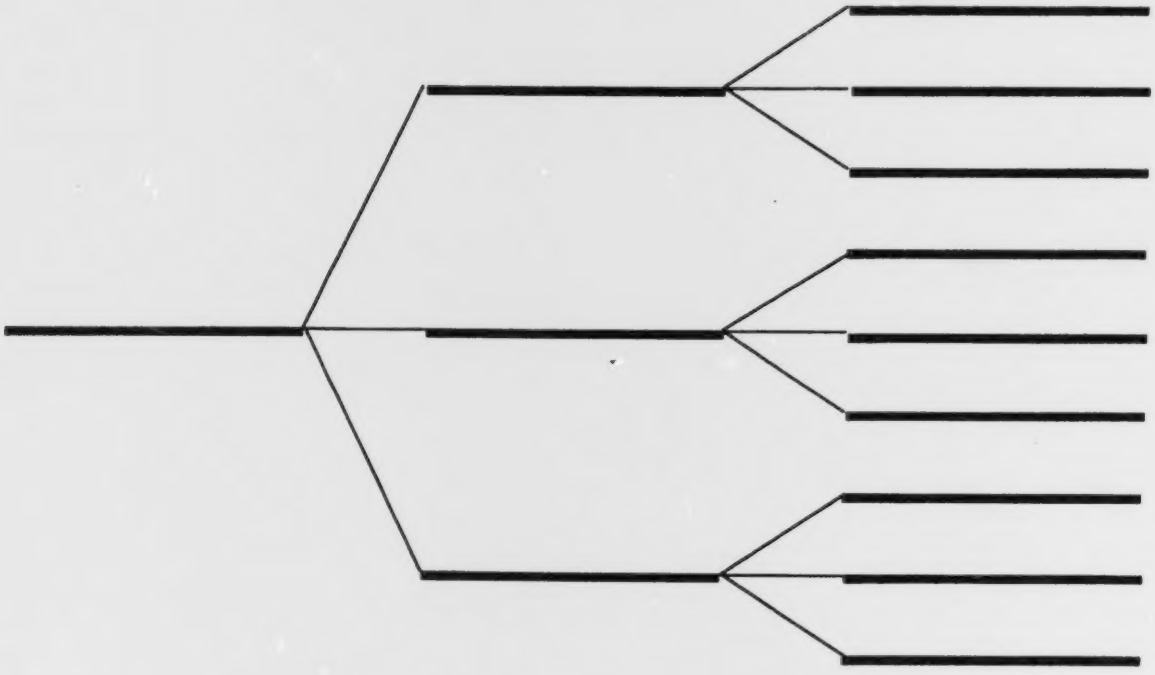
take no action on a particular issue. The tree will only be a success if most people take action most of the time.

These are the only things that each of us must do for the tree to work. If you are willing to do more, there is certainly more to do. We will need people to keep the tree working in each community and to keep the tree coordinator informed about how to make the tree work better and what issues need to be addressed.

HOW YOU CAN JOIN THE TELEPHONE TREE

Contact the Building Bridges Telephone Tree Coordinator at 563-0880 (Anchorage area) or 1-800-478-0880 (on the statewide toll free action line).

Sample Telephone Tree



Working Together Works!

Board Member Code of Ethics

Board members have an obligation to do more than just meet legal standards. Board members are expected to meet ethical standards of conduct as well. That's why many boards are adopting a code of ethics for board members. Below is one you can use for your board.

As a member of this board I will:

- Represent the interests of all the people served by this organization, and not favor any special interests inside or outside of this nonprofit.
- Not use my service on this board for my own personal advantage nor for the advantage of my friends or supporters.
- Keep confidential information confidential.
- Approach all board issues with an open mind, prepared to make the best decisions for everyone involved.
- Do nothing to violate the trust of those who elected or appointed me to the board or of those we serve.
- Focus my efforts on the mission of the nonprofit and not on my personal goals.
- Never exercise authority as a board member except when acting in a meeting with the required quorum of the full board or as I am delegated by the board.

Your signature Date

Your Board Member Hat

Congratulations! Whether you're a rookie or a veteran board member, you've taken on a very important role and can expect exciting times ahead. What you do as a board member will have great impact on your nonprofit or association for years to come!

But as exciting as your board term may be, it will also be challenging. You'll assume many different roles and wear many different hats as you respond to the various demands of your job.

That's why we have put together this manual. It's been designed as a guide to the roles and responsibilities you'll take on as a board member. I've divided the chapters to reflect the specific "hats" you can expect to wear during the upcoming year. But, in the meantime, here's a brief overview of your major responsibilities—you'll find more details about each in the following chapters.

Your responsibilities as a board member are to...

1) ***Meet the needs of the people you serve.*** When you get right down to it, the only reason your board exists is to serve your membership or the people in your community. So the "bottom line" of every decision you make should be, "How will this help us serve people better?"

2) ***Set policies that guide your organization.*** Remember that your primary function is to fashion the policies that ensure your organization is run effectively, legally and ethically. These policies are the foundation for your administrator — who is responsible for implementing your policies and managing the organization in accordance with them.

3) ***Write a plan outlining the long-range goals you have for your organization's growth and development.*** (These goals range from two to 10 years into the future.) This means you have to keep the "big picture" in mind. Remember that the long-term plans you formulate will be the guide for your administrator's short-term plans over the next 12 to 18 months.

4) ***Ensure that the agency has adequate finances and that the money is being spent responsibly.*** As you set policy and make plans for the future, you need to assess your ability to finance your plans — and make sure there's enough money in the coffers to cover your costs.

   Of course, as a "trustee" for your organization's money, you're also responsible for seeing that it is well-spent. This trustee role, however, doesn't mean you must approve every expenditure. What you need to do is determine that the money is being spent effectively to deliver the programs and services you've authorized. This can be done by financial and performance "audits" — not by personally examining where every penny goes.

5) ***Support your administrator.*** One of your most basic responsibilities is to support your administrator as he or she manages the daily operations of

your organization. Your role is to provide the direction that you want your administrator to take —then step back and let him or her decide just how to do that. Of course, you must also provide your administrator with the necessary resources to do the job.

You should always keep in mind that once you have given direction, you must let your administrator put that direction into actions. Expect feedback from the administrator, and evaluate your administrator on how well he or she leads your organization. Remember, however, that your job is to provide direction to the administrator, not to directly run the office.

Cultural Competency Toolkit

CHAPTER 2

Developing a Multi-Cultural Outreach Manual

The Mental Health Association of Allegheny County
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Brenda Lee, Project Director
Delores Burgess, Minority/Community Outreach and Education Coordinator

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Executive Summary

Prior to this grant proposal, the Mental Health Association of Allegheny County (MHAAC) participated as a founding member in a local Multicultural Outreach and Education Task Force. Designed to reach out to the underserved African American, Hispanic/Latino and elderly populations in Allegheny County, this task force helped to enroll 1,000 people in a newly created managed care system. MHAAC believed that this massive outreach project was highly replicable, and with a NCSTAC grant, they proposed to design and disseminate a how-to manual for other consumer supporter organizations to launch similar programs.

Project Goal

- To produce a manual for starting a minority behavioral health outreach and education program.

Introduction

Allegheny's elderly, Latino and African American communities were not accessing the health care that they needed.

Allegheny County is an urban area in Pennsylvania, home to the City of Pittsburgh. Two years before this grant proposal, MHAAC met with other service providers in the Pittsburgh area to discuss the dearth of information in the minority community concerning the county's new managed care system. At that time, a report issued by the Allegheny County HealthChoices Program indicated that elderly, Hispanic/Latino and African American communities in the area were not accessing the health care that they needed.

The report found that:

- Elderly persons represented only eight percent of the HealthChoices population, and they received authorizations for only two percent of the total authorized services.
- African Americans represented approximately ten percent of the Allegheny County population and almost half of the eligible HealthChoices population. Yet they received only approximately 37 percent of authorizations.
- Because of small numbers of individuals of Hispanic/Latino descent utilizing HealthCare services, this population was most likely also not accessing needed services.
- Caucasian members made up 51 percent of the eligible population but received 62 percent of the authorizations.

To address these disparities, and under MHAAC's leadership, a Multicultural Outreach and Education Task Force was formed. This task force then assisted more than 1,000 individuals to enroll in the existing managed care system over a two year period.

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Program Plan

The Multicultural Outreach and Education Task Force's success in enrolling so many new members into the existing managed care system convinced MHAAC that the project should be replicated. MHAAC proposed to NCSTAC to create a manual explaining to health care providers how to conduct multicultural outreach and education.

MHAAC helped to enroll more than 1,000 individuals in Allegheny's managed care system over a two-year period.

Organizational Overview

At the time of this grant proposal, MHAAC had already been providing services to Allegheny County residents for forty years. During this lengthy period, the staff had the opportunity to develop a wide network of connections with direct service providers, with those dispensing educational and informational resources, and with agencies providing ancillary services.

"I went out into the community and held conversations with people so that they could tell me what they needed."

— Delores Burgess, Minority Outreach Coordinator

During the two years directly preceding this grant, MHAAC participated in a variety of collaborative ventures with various agencies including: the Pennsylvania Office of Mental Health and Substance Abuse Services, the Office of Education and Regional Planning of the University of Pittsburgh, and Community College of Allegheny County.

MHAAC also worked together with local social service providers including: Hill House, Peoples Oakland, Renaissance Center, Mon Yough Community Services, Allegheny County Department of Human Services, Project CART (a consumer survey), New Horizons Mental Health Information Center, St. Francis Community Mental Health, Area Agency on Aging, Western Psychiatric Institute and Clinic, Coalition for Leadership, and Mayview State Hospital.

Ongoing projects at MHAAC included a Minority/Community Outreach and Education program, a Services to the Homeless program, a Family Support and Community Advocates initiative, a Substance Abuse and Advocacy program, and an Education Advocacy program.

Many people do not receive health care because:

- They lack information about available care.
- They lack adequate transportation.
- They have difficulty with child care.
- They carry inadequate insurance coverage.
- They are home bound.
- Their jobs limit their ability to keep appointments.
- Lack of cultural sensitivity by professionals keeps them from returning for needed services.

— From the *Step by Step Guide.*

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Implementation

Although project director, Brenda Lee, reports that "just finding the time" was the main challenge in completing this project, The *Step by Step Guide and Workbook for Starting a Minority Behavioral Health Outreach and Education Program* was finished in less than a year. (The main body of this workbook is included in the appendix.) Lee and Delores Burgess, the coordinator for MHAAC's Minority/Community Outreach and Education program, worked together on drafting this manual

Burgess, who developed the outreach program on which the manual was based, relied heavily upon her contacts in the field — providers, family members and consumers. She says, "I went out into the community and made the contacts and held conversations with people so that they could tell me what they liked and what they needed."

Organizations and individuals who would ultimately be served by the manual reviewed Burgess's and Lee's drafts and provided comments. The finished manual takes the reader through a series of questions such as "What are the barriers to access in your community?" and "What are the reasonable expectations of the community you will be serving?" that can provide guidance in creating a program appropriate for a particular community.

The finished manual takes readers through a series of questions that can provide guidance in creating an outreach program appropriate for a particular community.

Discussion and Conclusion

Now that the *Step by Step Guide* is complete, it will continue to be a resource for other groups wishing to conduct outreach and education. Burgess has already presented on the outreach program at various counties in the Allegheny area, as well as out of state, and she plans to distribute the manual "to other people who might want to start up a program like our own."

Lee warns anyone wishing to undertake community outreach that "it can be time consuming." But, she adds, "it's well worth it."

Additional Resources

Publications

(African Americans)

Byrd, W. Michael and Clayton, Linda A. *An American Health Dilemma, Volume One: A Medical History of African Americans and the Problem of Race: Beginnings to 1900.* New York: Routledge. 2000.

Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (Available on the internet at www.samhsa.gov/centers/cmhs/cmhs.html)

Mitchell, Angela, et al. *What the Blues Is All About: Black Women Overcoming Stress and Depression.* New York: Berkeley Publishing Group. 1998.

Pouissaint, Alvin and Alexander, Amy. *Lay My Burden Down: Unraveling Suicide and the Mental Health Crisis among African-Americans.* Boston: Beacon Press. 2000.

Villarosa, Linda (editor). *Body & Soul: The Black Women's Guide to Physical Health and Emotional Well-Being.* New York: HarperPerennial. 1994.

(Hispanic/Latino Americans)

Augenbraum, Harold et al. *Growing Up Latino: Memoirs and Stories.* Boston: Houghton Mifflin. 1993.

Garcia, Jorge and Zea, Maria (editors). *Psychological Interventions and Research With Latino Populations.* Boston: Allyn and Bacon. 1997.

Olmos, Edward (editor). *Americanos: Latino Life in the United States.* Boston: Little, Brown. 1999.

Padilla, Felix. *Latino Ethnic Consciousness: The Case of Mexican Americans and Puerto Ricans in Chicago.* Notre Dame, Indiana: University of Notre Dame Press. 1985.

(Older Americans)

Fogel, Barry S., Furino, Antonio and Gottlieb, Gary L. *Mental Health Policy for Older Americans: Protecting Minds at Risk.* Washington, D.C.: American Psychiatric Press. 1990.

Gatz, Margaret (editor). *Emerging Issues in Mental Health and Aging.* Washington, D.C.: American Psychological Association. 1995.

Knight, Bob. *Outreach With the Elderly: Community Education, Assessment and Therapy.* New York: New York University Press. 1989.

Smyer, Michael A. and Qualls, Sara H. *Aging and Mental Health (Understanding Aging).* Malden, Massachusetts: Blackwell Publishers. 1998.

Tice, Carolyn J. and Perkins, Kathleen R. *Mental Health Issues and Aging: Building on the Strengths of Older Persons.* Pacific Grove, California: Brooks/Cole. 1996.

Zarit, Steven H. and Zarit, Judy M. *Mental Disorders in Older Adults: Fundamentals of Assessment and Treatment.* New York: Guilford Press. 1998.

Organizations

American Association for Geriatric Psychiatry
7910 Woodmont Avenue, Bethesda, MD 20814-3004
Tel. (301) 654-7850
Fax. (301) 654-4137
E-mail: info@aagponline.org
Website: www.aagpgpa.org

Office of Minority Health
Department of Health and Human Resources
Tel. (800) 444-6472
E-mail: info@omhrc.gov
Website: www.omhrc.gov

United Seniors Health Cooperative
Suite 200 409 Third Street, S.W., Washington, D.C. 20024
Tel. (202) 479-6973
Fax. (202) 479-6660
E-mail: ushc@unitedseniorshealth.org
Website: www.unitedseniorshealth.org

Internet Resources

Medicare: The Official U.S. Government Site for Medicare Information. www.medicare.gov

Mental Health Association of Southeastern Pennsylvania: Mental Health and Aging. www.mhaging.org

STEP BY STEP GUIDE AND WORKBOOK FOR STARTING A MINORITY BEHAVIORAL HEALH OUTREACH AND EDUCATION PROGRAM

RULE FOR EFFECTIVE COMMUNITY OUTREACH

Effective community outreach involves local people, in their community, with their customs, speaking their language about their problems

INTRODUCTION

Outreach is defined as achieving changes that communities value.

Developing community outreach calls for person-to-person talk, not newspaper articles or ads, polls or slick publicity. It is not the community leaders and the behavioral health organization talking with and agreeing with each other. It is for members of the community to listen to and talk with each other about their problems.

This guide is intended to help behavioral health organizations overcome those barriers that exist when trying to offer programs and services in unserved or underserved communities

For many people, in a number of communities across the country, health care access is limited. For those who need behavioral health care it is even more limited. Many people do not receive health care because:

1. They lack the information about available health care.
2. They lack adequate transportation.
3. They have difficulty with childcare.
4. They carry inadequate insurance coverage.
5. They are home bound.

6. They work at jobs that limit their ability to keep medical appointments.

7. The lack of cultural sensitivity by some health care professionals often keep people from returning for needed services.

Example:

Problem: The community has an above average number of children with having difficulty in school.

Challenges: Parents don't respond to request from education professionals because of a distrust of the school system and school personnel; lack of understanding of what could be a emotional/behavioral disorder; and not wanting children "labeled."

Outreach: Talk with community members about the value of working with school personnel to identify problems that impact the ability for children to learn and function in the school setting and to ensure that all children in the community are in appropriate educational placements.

Goal: To get all children with emotional/behavioral disorders in the community in appropriate educational settings.

This guide sees a community as a place where people live who have characteristics distinguishing them from other people living in other communities. Distinguishing characteristics may be race, color, religion, language, education, geography, work situation, traditions, age and/or political belief. Often combinations of characteristics are lumped together and called *ethnic* neighborhoods.

Too often names of communities carry different meanings than intended. Terms such as *slum, ghetto, and barrio* can be more than a simple way of labeling an area. People who live in the community and call it *home* may hear these names as a put down and be offended. It is best to call the community by the name those that live there call it.

Community boundaries may not be clear but they are real. Once you enter a community the residents expect you to understand what they are doing in their words from their point of view. Without help, visitors may fail to meet this expectation and find unexpected barriers. Barriers include failure to understand the special meaning of race, geography, lack of education, particular views, color, money, or lack of interest in the community.

The gap between an outsider who is reaching into a community and the residents that live in that community can be vast. People doing outreach from the white majority or workers of different ethnic backgrounds should not be surprised when their motives are suspected, greetings ignored, and expressed goals dismissed by the residents of the targeted community

This guide will help you develop a plan to provide education and outreach services to individuals who are utilizing or may need to utilize the behavioral healthcare system – particularly minorities, those on public assistance and those receiving, or may be eligible to receive Medicaid.

It will identify nontraditional means of outreach and help you establish community partnerships with indigenous members of the community as well as community businesses, faith-based organizations and other organizations serving the targeted community.

This methodology uses a holistic approach to providing outreach and education. While the primary focus is on behavioral health, you must have available information on many other health care and human services.

The strength of this activity is in the collaborative effort of outreach and nontraditional partnerships that will be developed.

WHAT ARE THE BARRIERS TO ACCESS IN YOUR COMMUNITY?

REASONABLE EXPECTATIONS

The experiences of the Mental Health Association of Allegheny County find that:

1. **Reaching minority communities is sometimes difficult.** Frequently minority communities are walled off by fear and prejudices of people inside and outside the community. Crossing those barriers takes work that is best done through existing community organizations and networks.

    - Minority hosts should begin all community gatherings.
    - People want to see and hear people they know and trust.
    - People do not want to answer door-to-door surveys.

2. **Health care values differ from minority community to minority community.** Access to health care and the costs of adequate health are significant barriers to seeking health care for many members of minority communities. In addition, the culture of the community contributes to the traditions, circumstances and expectations of how people value health.

WHAT ARE THE REASONABLE EXPECTATIONS OF THE COMMUNITY YOU WILL BE SERVING?

DEVELOPING THE TEAM

The effective implementation of a Behavioral Health Education and Outreach Program relies on the development of a team. The team should be proportionally representative of the community to be served. Team members may include:

1. Representatives of the faith-based organizations located in the targeted community.
2. Representatives of the businesses located in the targeted community.
3. Community leaders including:
    a. Publicly elected officials.
    b. Leaders in public housing communities.
    c. Community activist.
    d. Youth leaders.
4. Representatives of the educational institutions in the community.
5. Other community healthcare providers.

Team members from community to community will vary.

WHO ARE THE MEMBERS OF YOU COMMUNITY THAT SHOULD BE A PART OF THE TEAM?

Once you have identified those individuals that need to be at the table you will want to bring them together at a time and place that is convenient to everyone (or almost everyone). Then:

- Perform general introductions. Introduce yourself and explain why you thought it was important to bring the group together. Ask each participant to introduce themselves and explain:
  - Why they agreed to participate in this project;
  - What do they hope to accomplish by being part of this project; and
  - What is the greatest asset they bring to the group?

LIST THOSE AT THE MEETING AND RECORD THEIR RESPONSES TO THE QUESTIONS ABOVE.

OVERVIEW OF THE PROJECT

Provide a brief overview of the benefits to healthcare outreach. To be effective the team members must:

- Foster ownership of the project.
- Have strong communication links to those they represent.
- Allow for active participation by the broader community.
- Be willing to work to increase the potential of achieving the mission and goals.
- Be sensitive to hidden prejudices, which may not be changed but certainly should never be aggravated.

LIST BELOW ADDITIONAL BENEFITS FOR TARGETED COMMUNITY.

TIME

Community outreach efforts need a schedule. The schedule should be detailed enough to indicate assignments for team members and allow reasonable time for them to complete the tasks. The schedule should not apply to community members who may have different ideas about time.

The schedule should be designed to accommodate the needs and customs of the targeted community. Community members who lack ready access to transportation can have trouble keeping appointments. People who do not show up the first time, may wish to attend but may be minimum-wage working people trying to keep their family going on less than it takes.

WHO'S SEATED AT THE TABLE

While this guide and workbook are designed to address behavioral health care issues, we have found that addressing healthcare in general is much less intimidating and more readily accepted in the communities where we are working. Once we've engaged the community we can then begin to discuss behavioral healthcare in the context of *achieving good health*. Therefore, we suggest encouraging people to talk about what healthcare issues exist in the targeted community. Some questions you might want to ask to stimulate conversation may include:

1. Is healthcare a priority in this community?
2. Why is it time to act?
3. How can the problems of under identification and treatment be made personal and urgent to community members?
4. Is the problem experienced differently by different parts of the community?
5. Identify the different segments of the community that you may wish to target. *(This list may be refined later.)*
6. Discuss how the identified segments of the community experience healthcare problems differently.
7. List the different needs as expressed.
8. Who else would be supportive of this effort and may be willing to help?
9. **WHO ELSE SHOULD BE AT THE TABLE?**

Community outreach demands that planning include local people, for example, members of the local faith-based organizations, community healthcare providers, community activists, etc.

Local leaders are not difficult to identify. Locate the community organizations with a reputation for effective service. These organizations can help identify leaders for the outreach tem because they are already working in and respected by members of the community.

Ask these leaders what they did to make a difference in the community. Ask them for suggestions and reactions to your outreach efforts. They can contribute immediate, practical insight for avoiding confusion, wasteful repetition and political rivalry. Finally, consider them for membership of the team.

IDENTIFY OTHER INDIVIDUALS WHO SHOULD BE ON THE TEAM.

TASKS TO BE COMPLETED BY THE END OF THE FIRST TEAM MEETING INCLUDE:

1. Establish a structure for the operation of the team including a method for recording outcomes.
2. Plan the next meeting.
3. Decide on a communication plan.
4. Discuss decision-making strategies.

VISION, MISSION AND GOALS

The team should spend time discussing and developing the vision, mission and goals of the outreach and education program. Discussion to help that process may include the following:

1. What has to happen for the program to have value to each member of the team?
2. Commit the mission and vision to writing.
3. Is it likely to happen, given the anticipated scope of the program?
4. Should additional goals and objectives be added?
5. Make sure that everyone is speaking the same *language*.
6. Write out the goals and determine how they will be measured.
7. Identify the core values of the group (what everyone will honor). These may include:
    a. Cultural Competence
    b. Responsibility for follow-up
    c. Confidentiality

DEVELOPING THE WORK PLAN

Review the Vision, Mission and Goals. Begin the discussion of the development of the work plan by addressing the following:

- Who will do what, when and with what result?
- Decide on the initial underserved population to be served. *(This may be broadened later.)*
- Discuss the value of targeting a certain population rather than the larger under- and/or unserved community.
- Spend time examining the cultural norms of the target community.
- Explore the core values and key concerns of the population to be served.
- Share outreach and education strategies for reaching the identified community,
- Is everyone at the table that needs to be there?
- What are the resources needed to implement the program?
- Determine the goals, objectives, action steps and expected outcomes of the education and outreach effort.
- Identify a leader or leaders for each targeted community.

TASK TO BE COMPLETED

Work plan developed with goals, objectives, action steps, outcomes, timelines, and costs.

NEXT STEPS AND SUGGESTIONS FOR SUCCESS

Begin working through the workplan using the action steps to achieve the identified goals and objectives and keeping within the established timelines.

Effective communication between team members ensures success. Some suggestions follow:

- All members of the team should be kept updated on activities of other team members.
- The team needs to meet on a regularly scheduled basis so that information may be shared and feedback given on activities.
- Team members should keep notes of activities so that they can report back to the team but it is best if they not take notes while in the community. Once they return home or to their offices, they should make notes on activities and things they want to report back to the full team while the information is still fresh in their minds.
- Questionnaires are usually not a good idea. Many of the communities you will be working in have been surveyed and questioned numerous times and generally distrust people doing surveys. Also, you should be mindful of the literacy level of the communities you are working in.
- Make sure residents of the community know that they are helping to make a difference in their community.
- Finally, make sure you always say "thank you."

EVALUATION

Developing an effective data collection system is essential to determining the effectiveness of the outreach efforts. Keeping in mind the confidentiality of those served, as well as the outcomes to be achieved, the team should determine:

- What information will be collected?
- How will it be collected?
- Who will collect it?
- How the information will be used to improve not only the outreach efforts but also the behavioral health delivery service in the community.

WHAT INFORMATION WILL YOU COLLECT AND HOW WILL YOU MEASURE YOUR OUTCOMES?

Cultural Competency Toolkit

CHAPTER 3

Project HOPE: Raising Depression Awareness in Georgia's African American Community

National Mental Health Association of Georgia
100 Edgewood Avenue, N.E.
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Fax. (404) 527-7187
Website: www.nmhag.org

Kristine Medea, Project Director
Cassandra Landry, Project Coordinator

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Executive Summary

With Project HOPE, (Healing, Opportunity, Prevention and Education), the National Mental Health Association of Georgia (NMHAG) aimed to increase awareness in Georgia's African American community of the symptoms of and treatments for depression. NMHAG planned to organize community outreach sessions both in the Atlanta metropolitan area and in rural Georgia—where they would provide information on depression as well as offer depression screenings and referrals. They would build up a referral database and collaborate with other existing organizations serving the African American community to encourage these other groups also to promote depression awareness.

Project Goals

- To offer public education on depression to African American audiences in Atlanta and in rural Georgia.
- To provide depression screenings and, where necessary, referrals.
- To develop a referral database of African American practitioners.
- To enter into collaborative partnerships with existing groups that serve African American people.
- To encourage community leaders to develop clinical services for the African American community that are culturally sound in practice.

Introduction

Any attempts to build cultural competency and to reach minority populations in the State of Georgia must confront some serious challenges. Approximately 27 percent of Georgia's population is African American and 71 percent is Caucasian. In the United States, Georgia is the fifth highest ranked state in African American population. At the same time, low utilization rates by African Americans of hospital and community based care suggests that this population is currently underserved.

Unfortunately, statistics have not historically been kept on depression and African Americans to the extent that statistics on depression and Caucasians have been kept. It is known, however, that among health professionals, there has been a consistent under-diagnosis of depression in the African American community. Clinical bias and underreporting of symptoms may contribute to this trend. The lower rates of diagnosis may also be attributed to socioeconomic factors (e.g., limited access to adequate medical care), mistrust of medical

There has been a consistent under-diagnosis of depression in the African American community. Clinical bias and underreporting of symptoms may contribute to this trend.

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health professionals, and a reliance on family and the religious community during periods of emotional distress instead of on the traditional western medical establishment.

In a National Mental Health Association survey, 63 percent of African Americans surveyed believed that depression was a personal weakness, compared to the overall survey average of 54 percent. Only 31 percent of African Americans surveyed said that they believed depression was a health problem and only one-third of African Americans said that they would take medication prescribed by a doctor—compared to over 69 percent of the general population surveyed.

Kristine Medea, project director, realizes that as a Caucasian woman she must rely upon African American leadership for direction and guidance.

Program Plan

In the face of these sobering statistics, NMHAG proposed a grant to continue its year-old Project HOPE campaign of providing public education about depression to the African American community throughout the state of Georgia. In its inaugural year, Project HOPE staff had provided direct training to nearly 100 individuals. In addition, these trainings had lead to further "spin-off" sessions that were implemented by Project HOPE program participants.

NMHAG now wished to expand Project HOPE by offering many more trainings throughout metropolitan Atlanta as well as in rural Georgia. They also aimed to provide depression screenings and, when necessary, referrals to African American practitioners. Finally, Project HOPE leaders intended to collaborate with other existing groups serving the African American community to encourage these groups also to promote depression awareness.

Organizational Overview

In April 1999, the Mental Health Association of Georgia and the Mental Health Association of Metropolitan Atlanta merged to create NMHAG. Together, these two organizations had accrued over 100 years of combined experience in mental health education, training and advocacy in Georgia.

With ample experience and many alliances, NMHAG was well-placed to provide more education on depression to more of Georgia's African Americans.

Over these many years of serving mental health consumers and their family members in Georgia, NMHAG had also developed a broad network of professional alliances. To name only some of these professional connections, NMHAG:

- staffed the Mental Health Services Coalition, with over 50 organizational members;
- co-chaired the Time for Community Coalition;
- co-chaired the Georgia Juvenile Justice Coalition;

- chaired the Mental Health Planning Council;
- served on the board of the Georgia Prevention Network;
- served on the Governor's Blue Ribbon Task Force on Community Based Services;
- served on the Medicaid Long Term Care Advisory committee;
- served on the Department on Human Resources' Hospital Closure Oversight Committee

With this ample experience and these many alliances within the mental health community, NMHAG was well-placed to expand Project HOPE to provide continued education on depression to more of Georgia's African Americans.

Implementation

In Project HOPE's second year, Cassandra Landry, program coordinator, presented on depression to some 1,500 individuals.

In Project HOPE's first year, education efforts focused primarily on African American clergy members and providers. In its second year, Cassandra Landry, the project coordinator, chose to reach out to the broader African American community, and her efforts to this end were enormous. In the program's second year, Landry presented on depression to some 1,500 individuals.

Primarily, Landry spoke at health fairs in Atlanta and across the state. She also presented at churches in some lower income areas, noting that "these are the areas where people are more in need because there are fewer resources."

In addition, Project HOPE arranged for Dr. Alvin Poussaint of the Judge Baker Children's Center in Boston and Faculty Associate Dean for Student Affairs at Harvard Medical School to speak at Georgia's Spellman University on African American women and psychotherapy. The event was a remarkable success, with over 200 individuals attending.

Through Project HOPE, 1,200 African Americans were also able to receive depression screenings. Individuals in need of further assistance were then referred to African American practitioners in their area. A referral database with information on African American mental health practitioners throughout the various regions in Georgia was developed in cooperation with the Primary Care Initiative (see Appendix C).

Project HOPE found that one of the most powerful ways to achieve its goals was through developing collaborative partnerships.

Project HOPE quickly found that one of the most powerful ways to achieve its goals was through developing collaborative partnerships. In its second year of operation, the program entered into various cooperative ventures. For example, depression screenings were offered in collaboration with the Georgia Academy of Family Physicians, the Fuqua Center for Late-Life Depression at Emory University, and NMHAG. Project HOPE also partnered with Delta Sigma Theta, a primarily African American national sorority, to bring depression screenings to the African American community.

In another initiative, Project HOPE worked with the Black Nurses' Association, the American Diabetes Association, the Black Cardiologists' Association of Atlanta, and the American Heart Association in order to train a group of twelve physicians in how to offer depression screenings. And in cooperation with the Primary Care Initiative, Project HOPE developed a referral database with information on African American mental health practitioners throughout the various regions in Georgia.

Project Hope's Strategic Partners

The American Diabetes Association

The American Heart Association

The Black Cardiologists' Association of Atlanta

The Black Nurses' Association

Delta Sigma Theta Sorority

The Fuqua Center for Late-Life Depression

Georgia Academy of Family Physicians

It is through these collaborative partnerships that Landry has seen Project HOPE "starting to take on a life of its own." As more and more organizations learn how to conduct outreach from Project HOPE, these groups can then begin to launch depression campaigns and offer screenings on their own. According to Landry, "it's starting with us, but then it's going to fill out and get off the ground... Soon it will be its own project."

Discussion

When considering the provision of mental health services for African Americans, Kristine Medea, Project HOPE's director, likes to give the example of a founder of the American Psychiatric Association who, in the mid-18th Century developed "diagnoses" for African Americans including one called "nigratude." As difficult as it is to even use such language today, it is important to be aware of the depth of institutionalized racism. The "treatment" for this "condition" was to administer beatings.

The question of providing appropriate services to the African American community is inextricably linked to the historic problems of prejudice and racism in this country.

It is no wonder, given the historic abuses that African Americans have faced in this country, that this community would be suspicious of white-dominated mental health systems. Indeed, the question of providing appropriate services to the African American community is inextricably linked to the historic problems of prejudice and racism in this country.

Landry points out that, as an African American, there were regions of southern Georgia that she was loathe to travel to in conducting public education for Project HOPE. "There's so much racism in some regions that that's the first issue that must be dealt with, and improving the quality of mental health care is only secondary."

Landry also gives the example of the training in southern Georgia where she expected 20 nurses to attend and only six arrived, because, she believes, the others were afraid of losing

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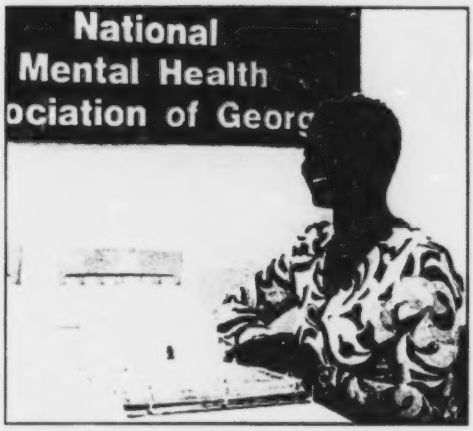

Cassandra Landry, project coordinator, is a child and adolescent therapist specialized in working with African Americans.

their jobs. "Maybe the hospital where they worked didn't want us giving information on outside referral possibilities," she hypothesizes.

Medea also readily acknowledges that many consumer supporter organizations are run primarily by Caucasians who may be hesitant to provide outreach to the African American community "primarily due to their own concerns about not being able to do it right." But Medea encourages such groups, saying that "they should not be afraid to start programs like this if they are invested in developing culturally competent programs."

The trick, she says, is to "realize that as a white person you can partner in such a project, but you cannot direct." Forming partnerships with African American organizations, and recruiting African American leaders is paramount. "As a white woman, I have to recruit leadership from within the African American community and then listen to that leadership," explains Medea. "It is the community, not me, that knows what is needed for healing."

Conclusion

Because of Project HOPE's many successes, it will continue to be an ongoing program at NMHAG. In the future, Medea and Landry intend to build ever more partnerships with African American organizations, and in particular, they plan to form more partnerships with faith-based organizations. Landry notes that the African American community is "grounded in spirituality." In addition, the two women also wish to extend their outreach further into rural Georgia.

Suggestions for Conducting Outreach to African Americans

- **Don't be afraid to start.**
  Even a predominantly Caucasian organization can do good work—provided it recruits African American leadership.
- **Reach out to the younger generation.**
  College and high school students may be more open to new ideas.
- **Form collaborative partnerships.**
  African American associations, schools, fraternities and sororities can help to get the word out.
- **Work with faith-based organizations.**
  Spirituality is a cornerstone in the African American community.

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Additional Resources

Publications

Byrd, W. Michael and Clayton, Linda A. *An American Health Dilemma, Volume One: A Medical History of African Americans and the Problem of Race: Beginnings to 1900.* New York: Routledge. 2000.

Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/ Underrepresented Racial/Ethnic Groups. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (Available on the internet at www.samhsa.gov/centers/cmhs/cmhs.html)

Mitchell, Angela, et al. *What the Blues Is All About : Black Women Overcoming Stress and Depression.* New York: Berkeley Publishing Group. 1998.

Pouissaint, Alvin and Alexander, Amy. *Lay My Burden Down: Unraveling Suicide and the Mental Health Crisis among African-Americans.* Boston: Beacon Press. 2000.

Villarosa, Linda (editor). *Body & Soul : The Black Women's Guide to Physical Health and Emotional Well-Being.* New York: HarperPerennial. 1994.

Organization

Office of Minority Health
Department of Health and Human Resources
Tel. (800) 444-6472
Email: info@omhrc.gov
Website: www.omhrc.gov

Ways to Support Project Hope

I want to help by:

- ☐ Making a monetary contribution $ _____
- ☐ Volunteering to
  - ☐ Participate in the speakers bureau
  - ☐ Organize an educational program
  - ☐ Clerical assistance

Name _____

Address _____

_____

_____

Phone _____

Method of Payment

- ☐ Check
- ☐ Visa
- ☐ MasterCard
- ☐ American Express

Credit Card # _____ Exp. date _____

Signature _____

National Mental Health Association of Georgia

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National Mental Health Association of Georgia

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Atlanta, Georgia 30303

PROJECT HOPE

Healing, Outreach, Prevention, Education

A Depression Awareness Campaign

It is important that black people talk to one another; that we talk with friends and allies, for the telling of our stories enables us to name our pain, our suffering and to seek healing.

bell hooks

Sisters of the Yam

Depression And African Americans

Every year approximately 19 million Americans will experience clinical depression according to the National Mental Health Association. Clinical depression is an equal opportunity illness that affects individuals regardless of race, class, sexual orientation or age. Historically, African-Americans had been considered incapable of experiencing depression because we were not emotionally sophisticated enough to experience emotional distress. This legacy of invalidation and silencing continues in the myth of the Strong Black Man/Woman. Project HOPE provides an opportunity to break the silence regarding depression and to link the African-American community with information and resources to support recovery from depression.

Symptoms of Depression

If you experience five or more of the following symptoms for more than two weeks you should talk with your doctor or mental health professional.

- Persistent sad or "empty" mood
- Sleeping too little or too much
- Change in weight or appetite
- Loss of pleasure or interest in activities
- Feeling restless or irritable
- Headaches, stomachaches and other physical symptoms that do not respond to treatment
- Difficulty concentrating, remembering or making decisions
- Fatigue or loss of energy

Project HOPE

Health Outreach, Prevention, Education

EDUCATION

Depression Dialogues- informal discussion groups where participants can exchange information about symptoms, treatment options and other resources to support recovery.

Speakers Bureau- Mental health consumers and professionals are available to conduct educational programs free of charge.

Professional Training- NMHAG offers professional training on a variety of mental health issues including multi-cultural counseling strategies.

ADVOCACY

Training-NMHAG offers advocacy training for individuals and groups who want to learn more about mental health public policy and funding priorities.

Mental Health Insurance Hotline
Provides guidance and support to consumers experiencing problems with accessing mental health insurance benefits. Callers can request insurance advocacy resource packet. Call (404) 527-7175 or (800) 933-9896.

INFORMATION AND REFERRAL

NMHAG operates an mental health resources information and referral line Monday-Friday 9:00 am - 5:00 pm. Call (404) 527-7175 for more information.

Depression Recovery Steps

- Get a complete physical to rule out other medical conditions.
- Get an evaluation from a qualified mental health professional.
- Create a circle of support. Tell friends and family about your depression and ask them for help.
- Tap into your spirituality as one resource for recovery.
- Remember that depression is an illness-not a weakness.

One touches one...touches one...

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Depression Screening Works!

"Family physicians can make a significant improvement in the lives of their patients with mental illnesses. Patients benefit from the continuity of care provided by their family physicians. Insight into the total health care needs of both the patient and family, including mental health needs, improves health care outcomes and patient quality of life" American Academy of Family Physicians.

With your help, we can work together to improve the way community based healthcare is provided in Georgia and help people realize that depression is a treatable illness.

North East Georgia Region

Barrow, Clarke, Greene, Jackson, Madison, Morgan, Ogelthorpe, and Oconee.

Timeline

- December 12th Leadership Council first meeting.
- Third week of January, physician and community focus group.
- Last week of January, meeting with physicians and their staff to implement depression screening initiative.
- Second week of February community town hall meeting

The National Mental Health Association of Georgia
For More Information Contact:

Kristine Medos, MA, ABS
Director, Clinical Education
kristine@nmhag.org
or
Jennifer Brewer, M.S.W.
Clinical Education Specialist
jennifer@nmhag.org
(404) 527-7175

The Georgia Physicians Depression Screening Initiative:
Integrating Mental Health and Primary Care

A collaboration between

- *National Mental Health Association of Georgia*
- *Georgia Academy of Family Physicians,*
- *Fuqua Center for Late-Life Depression a branch of Emory University*
- *Project Hope, an African American Depression Awareness Campaign*

Depression is an equal opportunity disease and over 19 million people suffer from it annually. The good news is depression screening works!

According to the surgeon generals report, 1 in 5 Americans will suffer from depression this year.

Women experience depression at roughly twice the rate as men; the highest rates of depression occur among adult's ages 25 to 44.

Late-life depression affects some six million older adults but only 10% of these persons ever get treatment. Depression is not a normal part of aging.

Nearly one-third of the patients primary care doctors see in a day will have significant depressive symptoms.

The Georgia Family Physicians Depression Screening Initiative is a collaborative effort that aims to improve the manner in which clinical depression is detected and diagnosed in primary care settings. It is our goal to:

- Increase the number of undiagnosed patients with depression who are in need of treatment.
- Increase access to treatment by educating, recruiting, and assisting family physicians in their effort to screen for depression.
- Decrease the stigma related to seeking treatment for depression by increasing Georgians awareness and understanding of late-life depression and depression in diverse populations.
- Relieve the excessive cost and time the family physician assumes when caring for a patient with untreated depression.

- Improve the overall patient experience by supporting an integrative healthcare environment in the primary care setting.

Since family physicians are the initial healthcare contact for most patients with depression, they are in a unique position to provide early intervention and integrated care for depression and coexisting medical illnesses. NMHAG, the Fuqua Center for Late-life Depression at Emory, The Georgia Academy for Family Physicians and Project Hope are here to offer several tools to assist the family physician.

What can we offer?

- **Free screening tools, with a choice of the ZUNG or HANDS.**
- **Local referral resource guide specific to your community.**
- **Free behavioral health literature for patients.**
- **Telephone consultation with geriatric psychiatrist, compliments of the Fuqua Center.**
- **Strategies to overcome cultural barriers when assessing and treating patients.**

Key:
Red: African American
Green: Older Adult
Orange: Women's Issues
Navy: Sliding Scale
Purple: Spanish Speaking
Brown: Gay, Lesbian, Bisexual, Trans
Teal: Children & Adolescents

The Primary Care Initiative:
Integrating Mental Health and Primary Care in Georgia

Northeast Georgia Mental Health Resources
Provided by: National Mental Health Association of Georgia
Northeast Georgia Mental Health Association

Specialties	Organization	License	Population Served	Service Provided	Address	Phone Number
African American **Spanish Speaking** **Sliding Scale** **Gay, Lesbian, Bisexual, Trans** Children & Adolescents	**Advantage Behavioral Health Systems Clarke County** *Accepts Medicare & Medicaid*	Licensed Clinical Social Worker, Licensed Professional Counselor, Psychiatrist, Psychologist	Public Mental Health Center Diverse Groups Severe and Persistent Mental Illness	Children Adolescents, and Adults Individual and Group counseling Medication	250 North Ave Athens, GA	**Athens** **(706) 542-8858** **24 hour** **(800) 387-8774** **Central Intake** **(800) 809-8864**
Older Adults	**NEGA Area Agency on Aging**	N/A	Public Senior Services Information and referral	Referral for senior mental health services	305 Research Dr Athens, GA	**(706) 369-5650**
Children & Adolescents	**Associates in Behavioral Health LLC** *Accepts Medicare*	Psychologist	Private Provider Diverse Groups	Children Adolescents, and Adults: Individual Counseling Family Therapy Psychological testing	700 Sunset Dr. Athens, GA	**(706) 543-7805**
African American for Children and Adolescents **Older Adults** Children & Adolescents	**Athens Psychotherapy Center** *Accepts Medicare and Medicaid for children*	Psychologist	Private Provider Diverse Groups	Children, Adolescents, and Adults Individual and Family Counseling	1751 S. Limpkin Athens, GA	**(706) 354-8158**

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Spanish Speaking Older Adults	**Athens Associates for Counseling and Psychotherapy** *Accepts Medicare*	Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist	Private Provider Diverse Groups Spanish Speaking	Children, Adolescents, and Adults Addiction Specialist, Eating Disorder Specialist, Individual and Family Counseling	598 S. Milledge Av. Athens, GA	**(706) 353-0709**
African American **Spanish Speaking** **Sliding Scale**	**Barrow County Mental Health Advantage Behavioral Health Systems** *Accepts Medicare & Medicaid*	Licensed Clinical Social Worker, Licensed Professional Counselor Psychiatry, Psychologist	Public Mental Health Center Diverse Groups Severe and Persistent Mental Illness	Children Adolescents, and Adults Individual and Group counseling Medication	98 Lanthier St. Winder, GA	**(770) 868-4150**
Sliding Scale	**Christian Psychotherapy Resources** *Accepts Medicare and Medicaid*	Licensed Professional Counselor, PhD.	Private Provider Christian Based Counseling	Individual, Family, and Group counseling	700 Sunset Dr. Athens, GA	**Athens and Winder (706) 353-8188**
Older Adults	**Council on Aging**	N/A	Public Senior Services information and referral	Alzheimer's respite Alzheimer's adult day facility Alzheimer's support and caregiver group Home delivered meals	135 Hoyt St. Athens, GA	**(706) 549-4850**
	Dr. David Jarrett and Associates *Accepts Medicare*	Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Psychiatrist	Private provider Severe and persistent mental illness Diverse groups	Psychotherapy 14 years and older Family and individual therapy	1721 Prince Ave. Athens, GA	**(706) 543-8088**
Spanish Speaking Older Adults **Sliding Scale**	**Family Counseling Service Inc.**	Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist	Private Provider Diverse groups Spanish Speaking	Individual and Family counseling Children, Adolescents, and Adults Domestic Violence Counseling	1435 Oglethorpe Ave Athens, GA	**Athens (706) 549-7755 Winder (706) 307-1533 Jefferson (706) 367-5414 Danielsville (706) 795-3995 Watkinsville (706) 549-7755**

Older Adults	**Fuqua Center for Late-Life Depression** *Accepts Medicare & Medicaid*	Psychiatry, MD, MSN, FNP, GNP	No fee geriatric phone consultation Provides information, referral, and case management specific to your community	Individual and Group counseling Medication Referral for senior mental health services Inpatient hospitalization	1841 Clifton Rd., NE 4th floor Atlanta, GA 30329	**(404) 728-6302**
Spanish Speaking **Sliding Scale**	**Greensboro County Mental Health Advantage Behavioral Health Systems** *Accepts Medicare & Medicaid*	Licensed Clinical Social Worker, Licensed Professional Counselor Psychiatry, Psychologist	Public Mental Health Center Diverse Groups Severe and Persistent Mental Illness	Children Adolescents, and Adults Individual and Group counseling Medication	1040 Silver Rd Greensboro, GA	**(706) 453-2301**
Spanish Speaking **Sliding Scale**	**Jackson County Mental Health Advantage Behavioral Health Systems** *Accepts Medicare & Medicaid*	Licensed Clinical Social Worker, Licensed Professional Counselor Psychiatry, Psychologist	Public Mental Health Center Diverse Groups Severe and Persistent Mental Illness	Children Adolescents, and Adults Individual and Group counseling Medication	515 Darnell Rd. Jefferson, GA	**(706) 367-5258**
Spanish Speaking **Sliding Scale**	**Madison County Mental Health Advantage Behavioral Health Systems** *Accepts Medicare & Medicaid*	Licensed Clinical Social Worker, Licensed Professional Counselor Psychiatry, Psychologist	Public Mental Health Center Diverse Groups Severe and Persistent Mental Illness	Children Adolescents, and Adults Individual and Group counseling	Multi-Purpose Bldg Danielsville, GA	**(706) 795-2187**
Sliding Scale	**Monroe Counseling Center**	Licensed Marriage and Family Therapist	Private Provider	Individual and Family counseling Children, Adolescents, and Adults	202 McDaniel St. Monroe, GA	**(770) 267-6161**
African American Older Adults **Spanish Speaking Resources** Women **Gay, Lesbian, Bisexual, Trans,** **Clinician**	**National Mental Health Association of Georgia**	Licensed Clinical Social Worker, Marriage Family Therapist, Master of Social Work	No Fee information and referral information specific to your community Advocacy and community education association	No counseling offered however can provide patient or physician specific community providers	100 Edgewood Ave. Suite 502 Atlanta, GA 30303	**(404) 527-7175**

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Spanish Speaking	The Psychotherapy Group	Licensed Clinical Social Worker, Licensed Marriage and Family Therapist	Private Provider Diverse Groups Spanish Speaking	Children, Adolescents, and Adults Individual and Family Counseling Trauma recovery Center Christian Counseling Art Therapy Hypnotherapy	1551 Jennings Mill Rd. Bogart, GA	(706) 369-0697
Spanish Speaking Sliding Scale	Samaritan Counseling Center	Licensed Clinical Social Worker, Licensed Marriage and Family Therapist	Private Provider Diverse Groups Spanish Speaking	Children, Adolescents, and Adults Individual and Family Counseling	1690 S. Milledge Av. Athens, GA	(706) 769-1718
	Stresscare Inc	Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist	Private Provider	Children, Adolescents, and Adults Individual and Family Counseling	1030 Village Dr. Watkinsville, GA	(706) 769-1718

This complimentary mental health resource guide is provided to you by the National Mental Health Association of Georgia and we want to know what you think! Please let us know if you experience repeated concerns with any of the providers in this resource guide. You may contact us at the following address:

National Mental Health Association of Georgia
100 Edgewood Ave., Suite 502
Atlanta, GA 30303
(404) 527-7175
(404) 527-7187 fax

In addition, for geriatric specific concerns please contact:
Fuqua Center for Late-Life Depression
Wesley Woods Health Center
1841 Clifton Rd.,
Atlanta, GA 30329
(404) 728-6302
(404) 728-6269

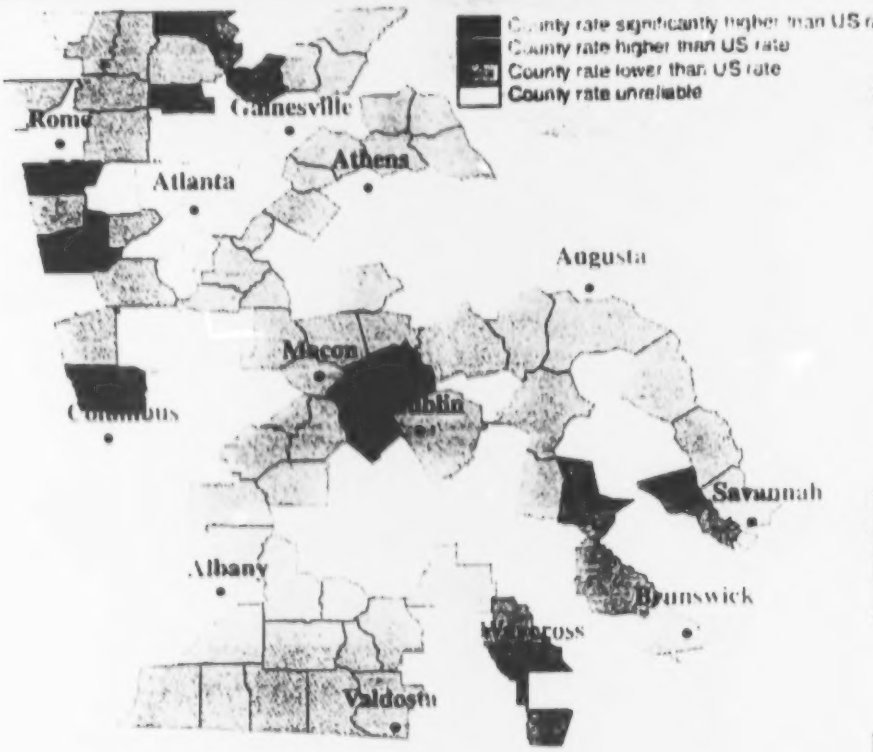
Suicide in Georgia: 2000

State and County Statistics
Strategic Plans

About 850 Georgians die every year from suicide

More Georgians die from suicide than homicide

Georgia County Suicide Rates, 1994 - 1998



Georgia Department of Human Resources / Division of Public Health

AFSP

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Depression & Spirituality

Symptoms Of Depression:

-Sadness
-Inactivity
-Difficulty sleeping or sleeping excessively
-Difficulty in thinking and concentration
-Increase in appetite
-Decrease in appetite
-Feelings of dejection
-Feelings of hopelessness
-Isolation from others

*If Depression is not treated after a period of time, it can lead to suicidal tendencies.

Recommended Treatment for Depression:

-Medication (i.e. Prozac, Zoloft and etc.)
-Psychiatric Counseling
-Meditation daily with God

Scriptures for Daily Meditation:

-Psalm- 19:14 (Let the words of my mouth, and the mediation of my heart, be acceptable in thy sight, O Lord, my strength and my redeemer).

-Psalms-23 rd chapter
-Psalms- 63:6
-St. John- Chapter 11
-Psalms-5: 1
-Hebrews 5:8
-1 Peter 2:21
-Luke 6:21

Scripture for today- I can do all things through Christ who strengthens Me.

DEPRESSION OVERVIEW

Definition

A down mood along with other symptoms which last for a couple of weeks. Clinical depression a serious health problem that affects the total person in addition to feelings, it can change behavior, physical health and appearance, academic performance and the ability to handle everyday decisions and pressures.

Causes

We do not know what causes depression but there seems to be a biological and emotional factor that may increase the likelihood that an individual will develop a depressive disorder. Research has strongly suggest a genetic link to depressive disorder, depression can run in families. Bad life experiences and stress.

Symptoms

Empty or sad mood
Loss of interest or pleasure in things you use to do
Decrease energy or feeling slow
Sleep disturbances
Eating disturbances
Difficulty concentrating or remembering things
Feelings of hopelessness
Feelings of guilt
Thoughts of death or suicide
Excessive Crying
Chronic aches or pains that do not respond to treatment

WORKSHEET

African Americans and Depression

Cultural background often plays a role in hoe the symptoms of depression are reported and interpreted and a clinical role in hoe and if clinical depression is recognized and treated appropriately.

The idea that blacks were intellectually and emotionally inferior which is a stereotype perceived during slavery still somewhat exist and often leads to improper diagnosis.

A century century old belief that African Americans were incapable of depression or that dynamic psychotherapies were inappropriate which therefore means Afican American were not treated for all treatment modalities.

To date the majority of mental illness research has been done only on white males

Several barriers to proper diagnosis of African Americans exist such a verbal cues
Which can easily be misinterpreted or overlooked by psychiatrists not trained to recognize cultural differences.

Additional barriers:

African Americans attitudes toward the medical community and mental illness itself(PROJECT HOPE)

There is a general mistrust of the medical professional within the African American Community.

Psychiatry is seen as taboo only crazy or bad people see this kind of doctor.

The African American community emphasizes spiritual and religious support during times of emotional stress therefore many people feel that prayer and faith are the only acceptable option for treating depression

CHALLENGES

The Challenged for diagnosing clinical depression among African Americans are as follow:

*The health care professionals must understand the cultural differences that prevent proper diagnosis

*African American must be made aware that depression is treatable and that seeking the help is an important part to recovery

African Americans are more likely to :

*describe themselves as worn out instead of feeling sad or say their last nerve is being worked as opposed to I feel irritable

*We are less likel;y to report symptoms most often associated with depression such as feeling fatique and irritable

MOST COMMOM SYPTOM OF AFRICAN AMERICAN WOMEN WHO ARE DEPRESSED IS EXCESSIVE WEIGHT GAIN AND CHANGES IN APPETITE

TREATMENTS

There are 3 types of treatment

Medication
Psychosocial Therapy

Medication
Most commonly used

Prozac
Zoloft
Paxil

TALK ABOUT NATURAL HERBS

Psychosocial Therapy
Consist of attending indivdual therapy, Family therapy, or group therapy
Therapy is an out let which allows an individual to talk about their problems and resolved through the emotional support insights and understanding

Other types of therapies concentrate on behaviors: patient are taught to be more effective in obtaining rewards and satisfaction through their own actions.

Oahu's "Mixed Plate" Speakers Bureau

The Mental Health Association in Hawai'i
200 N. Vineyard Blvd., Suite 300
Honolulu, Hawaii 96817
Tel. (808) 521-1846
Fax. (808) 533-6995

Paula Heim, Project Director
Kaanoi Kaapana, Public Education Assistant

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Executive Summary

The Mental Health Association in Hawaii (MHAH) used its NCSTAC funding to strengthen its existing speakers bureau by recruiting and training mental health consumers of different cultural backgrounds. Over the course of this project, MHAH recruited eight Native Hawaiian and Asian American consumers, provided them with training in mental health education and advocacy and in developing public speaking skills, and organized engagements for these new leaders to speak and advocate in the community.

Project Goals

- To locate potential leaders in various ethnic groups.
- To provide public speaking and mental health training to consumer leaders.
- To facilitate a series of community speaking engagements.

Introduction

Hawaii, with its long history of hosting immigrant workers, is one of the country's most ethnically diverse states. In the 19th and 20th Centuries, families from the far corners of the globe — Japan, China, the Philippines, Portugal, even Scandinavia — migrated to this chain of islands in the South Pacific to build new lives for themselves as plantation workers. Today, the State Health Department reports the breakdown of ethnicity in Hawaii as 21.9 percent Caucasian, 20.6 percent Hawaiian or part Hawaiian, 19.4 percent mixed Asian, 18.2 percent Japanese, and 12.7 percent Filipino. Chinese, Korean, Samoan, and African Americans make up an additional four percent of the population.

Hawaii, with its long history of hosting immigrant workers, is one of the country's most ethnically diverse states.

Hawaiians take pride in their diverse heritage, and a popular offering at the local eateries remains the "mixed plate"—a sampling of various dishes representative of different local ethnic groups. In this spirit of embracing diversity, MHAH proposed to expand its existing speakers bureau into a "Mixed Plate Bureau," by recruiting and training Native Hawaiian and Asian American consumers in order to reach out to a broader spectrum of Oahu's population.

The speakers bureau was decisive in preventing the closing of the Diamond Head Day Treatment Center, shown here.

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Organizational Overview

Before launching the Mixed Plate project, MHAH already had a long and successful history of providing public education and promoting consumer involvement in public policy by empowering consumer volunteers. Founded in 1942, the small but robust organization has been active in Hawaii for 58 years.

In 1998, key projects for the association included working with the Equal Insurance Coverage Coalition, presenting healthcare reform and advocacy trainings, and helping the State Department of Health and the Department of Human Services to establish an ombudsprogram. All of this was accomplished with a staff of five, a volunteer legal counsel, and 18 volunteers serving on the Board of Directors. At the time of this project's inception in 1999, MHAH was also fortunate to be able to draw upon the talents of some 50 consumer volunteers.

Paula Heim, project director, saw the need to reach out to Oahu's Asian-American and Hawaiian Native communities.

The Oahu Speakers bureau, the foundation for this project, was already a thriving, active body. In 1998, the bureau, comprised entirely of consumer volunteers, presented talks to over 4,000 people to reduce the persistent and destructive myths surrounding mental illness. In applying for this grant, however, Paula Heim, the project director, saw the need to reach out with this bureau to Oahu's Asian American and Hawaiian Native communities.

Implementation

In May and June, MHAH invited interested consumers to join the speakers bureau by publicizing a series of training workshops for potential bureau members. Notice of the workshops was included in the association's quarterly newsletter, and faxes were sent to local community mental health centers and clubhouses. A sample recruitment flyer is included in the appendices. Initially, ten consumers were recruited, and eight of these individuals completed the entire training agenda to become active members of the speakers bureau.

Kaanoi Kaapana, MHAH's public education assistant developed the four educational workshops designed to teach interested consumers how to become savvy mental health advocates. Workshops, which lasted from two to six hours, provided an overview of the mental health system in Hawaii and gave consumers opportunities to develop their public speaking and presentation skills.

Immediately after completing their trainings, the new Mixed Plate Speakers Bureau took on a rigorous agenda of public education and advocacy. From October 2000 through January 2001, they offered twelve presentations at local high schools, universities, television programs and churches serving Asian Americans and Native Hawaiians.

Besides providing an overview of mental illnesses and discussing the available health services in Oahu, speakers also tackled many cultural misconceptions about mental illnesses—explaining that these diseases are not the results of sin or weakness. Just how the

Speakers Bureau Presentation Schedule

Date	Location	Audience
10/09/00	Local restaurant	Religious leaders
10/20/00	Trinity Broadcast (TV 26)	Christian
10/26/00	Trinity Broadcast (TV 26)	Christian
11/02/00	Farrington High School	Adolescents
11/03/00	Mid-Pacific Institute	Adolescents
11/09/00	Moanalua High School	Adolescents
11/15/00	Nanakuli High School	Adolescents
11/16/00	Hawaii Baptist Academy	Adolescents
11/22/00	Kamehameha School	Adolescents
11/27/00	First Christian Church	Church outreach
01/17/01	Nanakuli High School	Adolescents
02/02/01	St. Andrew's Cathedral	Symposium
02/07/01	University of Hawaii	Graduate students

bureau tailored its approaches to different ethnic communities will be explored more fully in the discussion section.

Speaker bureau members also jumped feet-first into public advocacy with the impending closing of the Diamond Head Life-Skills and Mental Health Treatment Services Center, a local community treatment program providing a vast array of services to mental health consumers from dental treatment to emergency assistance to life-skills training. According to Heim, bureau members "lobbied vigorously" in the media and at legislative meetings against the closing of Diamond Head, and due to their efforts the Center is still open and running today.

Finally, Heim also called upon speakers bureau members to assist in MHAH's voter empowerment project, an effort to register mental health consumers to vote and to provide public education on candidates and policy issues.

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Discussion

Brian Oishi, a Hawaiian of Japanese descent and a member of the Mixed Plate Speakers Bureau, has a story he loves to tell: When he first started experiencing psychiatric symptoms as a young man, he went to his Auntie and asked her for help. His Auntie heard him out and then told him not to worry, because in a week he would receive the help he needed.

To find a common ground that respects traditional values while still addressing consumers' medical needs is the challenge of cultural competency.

Oishi was relieved and eagerly waited for the promised cure only to be presented, after a week, with a cucumber. Etched on the cucumber were characters in Japanese. His Auntie explained to him that he was supposed to rub the cucumber over his head and he would get better.

"You can imagine my disappointment," says Oishi, when he retells this story. "I had been waiting a week and I thought I would get better, and all I got was this cucumber. But I knew that I had serious problems and I knew that I needed some kind of real medicine."

Oishi ended up "rebelling" by seeking Western medical attention for his mental health problems. He credits this medical attention with allowing him to be the capable consumer advocate that he is today.

Kaapana, also a mental health consumer and of Native Hawaiian descent uses remarkably similar language: "I rebelled to get the help I needed." In traditional Hawaiian culture, she explains, problems are addressed through spiritual healing and through a tradition of "open discussion" which "always takes place only within the family." Prayers and rituals are used, "but no one consults a professional psychiatrist. It is a matter of pride and respect to solve problems only within the family."

"The Mixed Plate Speakers Bureau workshops empowered me with the confidence, ability and desire to take action through testimony and advocacy."

—Charlene Ryerson, speakers bureau member

Finding common ground

To find a common ground that respects traditional values while still addressing the very real medical needs of people with mental illness is the challenge of cultural competency. For Heim, who is herself part Chinese American and part Hawaiian, and for Kaapana, discovering how best to reach out to Hawaii's various ethnic communities has been an ongoing process.

They cite numerous examples of cultural attitudes that could possibly present a barrier to seeking mental health services. In general, states Heim, "there is still a lot of distrust among Asian Americans of western medicine. Some societies in Hawaii see mental illness as a punishment by God. It is therefore considered a shame to the family to be mentally ill—especially among the Japanese, for example, it is shameful to even speak of mental illness."

Or in the Chinese culture, drawing any attention to oneself—even when asking for help—can be considered "boasting." "The younger generation," says Heim, "is supposed to learn by listening and watching. Asking questions is not required or welcomed."

But Heim, Kaapana and the members of the speakers bureau have found ways to bring their message to diverse groups. Heim says that because of the stigma surrounding mental illness, one of the main focuses of public education must be simply, gently "to try to get people to acknowledge to themselves that something is wrong." Once individuals can take this step, and once they see the example of speakers bureau members living productive lives of recovery, they can be encouraged to seek the help they need.

MHAH has learned to take advantage of the traditional leadership provided by members of the older generation, the "kupuna."

In working with the Native Hawaiian population, Kaapana has learned to take advantage of the traditional leadership provided by members of the older generation, the "kupuna." "We always go to the kupuna first and explain what we're doing before doing outreach." Once a public presentation has received the nod from the kupuna, it is far more likely to be attended and accepted by other community members.

Culture, not language

Initially, MHHA proposed to provide public education materials in different Asian languages as part this project. They collected informational brochures produced in Chinese from SmithKline Beecham but soon discovered that paying to translate materials would be prohibitively expensive.

Members of the Mixed Plate Speakers Bureau represent Hawaii's various native and Asian-American communities.

At the same time, they found that providing translated materials to Oahu's Asian communities was not really necessary. As opposed to mainland Asian American communities, "most people are second, third, fourth or even later generation Americans," Heim explains. Usually, English is spoken as a second language in the home." Consequently it is more a cultural than a language barrier that public educators in Hawaii must bridge.

Conclusion

Thanks to the funding this grant has provided, the Mixed Plate Speakers Bureau will continue to thrive. To date, three new consumers have been recruited in addition to the eight already in the program. With an additional grant opportunity from the National Institutes of Mental Health, MHAH will also expand the speakers bureau into a faith based community outreach program in cooperation with Pacific Health Ministry and community religious leaders. In this way, MHAH can continue to serve its ethnically diverse population while being respectful of its rich cultural heritage.

Additional Resources

Publications

(Asian Americans)

Takaki, Ronald. *Strangers from a Different Shore: A History of Asian Americans.* Boston: Little, Brown. 1998.

Tuan, Mia. *Forever Foreigners or Honorary Whites?: The Asian Ethnic Experience Today.* New Brunswick, New Jersey: Rutgers University Press. 1998.

Uba, Laura. *Asian Americans: Personality Patterns, Identity, and Mental Health.* New York: Guilford Press. 1994.

Zia, Helen. *Asian American Dreams: The Emergence of an American People.* New York: Farrar, Straus, and Giroux. 2000.

(Native Hawaiians)

Gallimore, Ronald. *Culture, Behavior, and Education: A Study of Hawaiian-Americans.* Beverly Hills, California: Sage Publications. 1974.

Kape'Ahiokalani Maenette et al. *Culture and Educational Policy in Hawaii: The Silencing of Native Voices.* Mahwah, New Jersey: L. Erlbaum Associates. 1998.

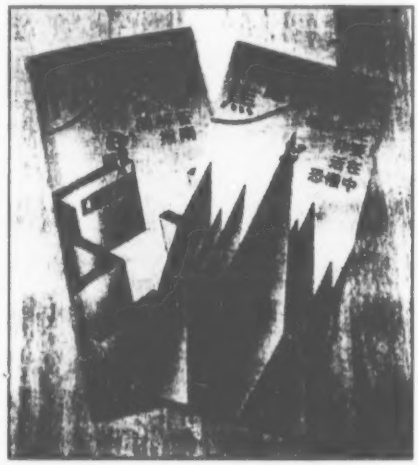
Native Outreach: A Report to American Indian, Alaska Native, and Native Hawaiian Communities. Bethesda, Maryland: National Institutes of Health and National Cancer Institute. 1999.

Organizations

Bernice Pauahi Bishop Museum
The State Museum of Natural and Cultural History
1525 Bernice Street, Honolulu Hawaii 96817-2704
Tel. (808) 847-3511 Website: www.bishop.hawaii.org

The Chinese Chamber of Commerce in Hawaii
42 N. King Street, Honolulu, Hawaii 96813
Tel. (808) 533-3181 Fax. (808) 533-6967
Email: info@ccchi.org Website: www.ccchi.org

Office of Minority Health
Department of Health and Human Resources
Tel. (800) 444-6472 Email: info@omhrc.gov
Website: www.omhrc.gov



SmithKline Beecham provided educational materials in Chinese.

Internet Resources

The Evolution of Identity in Hawaii: A Group Independent Study Project, http://www.brown.edu/Students/Brown_Hawaii_Club/HI_GISP/Index.html

Hawaiian Cultural Preservation Association, http://hawaiiancultural.org

— FREE WORKSHOP —
PUBLIC SPEAKING AND MENTAL HEALTH

Do you speak Chinese, Japanese, Korean, Hawaiian language, or any Filipino dialects in addition to English?

YOUR TALENT IS NEEDED

Mental Health Association in Hawa'i is looking for speakers on O'ahu to join our "Mixed Plate" Speakers Bureau. Now's the time for consumers, family members, and mental health professionals to promote good mental health and educate schools, businesses, and church groups .

Where: Diamond Head Mental Health Center
Life Skills Program, Room 418

When: 9:00 am to 3:00 pm, Thursday, June 22, 2000
Lunch is included

To register, contact Kaanoi Agunat at 521-1846.

HELP FIGHT FEAR AND MISUNDERSTANDING ABOUT PEOPLE WITH MENTAL ILLNESSES!

> ***'A 'ohe hana nui ke alu 'ia***
> *No task is too big when done together by all*
> *- 'Olelo No'eau*

Agenda
Mixed Plate Speakers Bureau

June 22, 2000 (Thursday)
9:00 am - 3:00 pm

9:00 am - 10:00 am
- -Introduction & Welcome
  - -Speaker Profile
- -What the Mixed Plate Speakers Bureau is all about
  - -Importance of the speakers bureau
  - -Who is involved in the speakers bureau
  - -The idea of mixed plate

10:00 am - 10:30 am
- -Mental Health Association's goals and what we hope to achieve, as well as your expectations as a volunteer
  - -6 goals/strategies of MHA
  - -What MHA hopes to achieve/Expectations (Outcome)
  - -Volunteers expectations

10:30 am - 11:30 am
- -Agenda for the day
  - -Hawai'i statistics
  - -Presentation basics (focus on public speaking)
  - -Miscellaneous

11:30 am - 12:30 pm
- -Lunch

12:30 pm - 1:30 pm
- -Continue presentation basics

1:30 pm - 1:45 pm
- -Break

1:45 pm - 3:00 pm
- -Next steps
- -Questions
- -Collect Speaker profile/Workshop evaluation

I. Main Point: What the Mixed Plate Speakers Bureau is all about.

A. Why is it important

B. Who is involved in the speakers bureau

C. Background of Mixed Plate.

II. Main Point: Mental Health Association's goals and what we hope to achieve, as well as your expectations as a volunteer.

A. Goals/Strategies of MHA

B. What MHA hopes to achieve/Expectations (Outcome)

C. Volunteers Expectations

III. Main Point: Agenda for the day.

A. Hawai'i Statistics (Facts and Figures)

B. Presentation basics (focus on public speaking)

C. Miscellaneous

Speech Outline

Specific purpose:

Introduction

I. Open with impact:

II. Focus on thesis statement:

III. Connect with audience:

Body

Preview:

I. Main Point:

A.

B.

C.

Signpost:

II. Main Point:

Signpost:

III. Main Point:

Signpost:

Conclusion

I. Summarize

II. Close with impact

Speaker's Note Cards

Example topic: High School talk about depression

INTRO
I. Introduce yourself; you represent Mental Health Association in Hawai'i
II. Summarize the topic in a few sentences
III. Pass out pre-tests before presentation (Outcome)

BODY
I. Depression, the medical illness
- **A. Depression as a chemical imbalance**
- **B. The stigma attached to a mental illness - unified mental health message**
- **C. The symptoms/risk factors of depression**

II. Personal experiences with depression
- **A. How does it feel to have depression**
- **B. How you dealt with the stigma**
- **C. What your life has been like, experiencing depression**

• remember not to suggest things when talking about personal experiences - medication, medical coverage, support groups, etc.

III. Resources/How do I get help
- **A. How do I tell my parents**
- **B. How do I get help**
- **C. What do I do when a friend is depressed**

CONCLUSION
I. Summarize - again stating the unified mental health message
II. Pass out brochures; finish post-test
III. Questions/Comments from students

Mental Health Association in Hawai'i
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(808)521-1846; Fax 533-6995; E-mail: mha@i-one.com

Mixed Plate Speakers Bureau
Workshop Evaluation I
Thursday, June 22, 2000 - Diamond Head Life Skills

1. How long have you been involved with the Speakers Bureau?

2. How long have you been involved with MHA in Hawai'i?

3. What were your expectations before the workshop?

4. Did the presenter meet your expectations? If not, why not?

5. What did you learn from this workshop?

6. Was the presentation well-organized and professional?

7. Were the materials you saw and received useful to you?

8. Would you like to attend additional workshops if offered?
   If so, how often would you like to see them?

9. Suggest topics or areas of concern for additional workshops here:

Mahalo plenty for attending our workshop and giving of yourself so that others can learn!

Your participation in the Speakers Bureau is greatly appreciated and we value your suggestions for improvement. Please write any additional comments here:

Mental Health Association in Hawai'i

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Speaker Profile

(Completed___/___/___)

Personal Information:

Name: _____

Home Address: _____

_____ Phone: _____

Position: _____

Company or Organization: _____

Business Address: _____

_____ Phone: _____

Fax: _____ Pager: _____ Cell: _____

Speak About:

Other affiliations or support groups: _____

Preferred topic(s): _____

Mental health background: _____

Previous speaking experience: _____

Availability: (Check any that apply)

_____ Morning

_____ Afternoons

_____ Evenings

_____ Only on _____ days

_____ Early-bird (4:00-6:30 a.m.)

_____ On short notice

_____ Weekends

Location: (List areas you are not willing to travel)

_____

Audience preferences: (check any that apply):

_____ Small groups (10-30 people)

_____ Children (Elem./Inter.)

_____ Adults (College and above)

_____ Men only

_____ Bilingual (please list language(s)

_____ Large groups (30+ people)

_____ Teens (High School Age)

_____ Sr. Citizens

_____ Women only

Mixed Plate Speakers Bureau

Workshop II

Where: Diamond Head Mental Health Center

Life Skills Program, Room 418

When: Wednesday, July 12, 2000

9:30 am - 11:00 am

Snacks will be provided

To register, contact Kaanoi Agunat at 521-1846

Join us once again as we focus our discussion on public speaking and speaking engagements. Please bring with you the literature packets and handouts from Workshop I.

The unified mental health message is:
"Mental illnesses are REAL, COMMON, DIAGNOSABLE, and TREATABLE."

Help us continue to fight the fear and misunderstanding of people with mental illnesses.

Agenda

Mixed Plate Speakers Bureau

Workshop II

July 12, 2000 (Wednesday)
9:30 am - 11:00 pm

9:30 am - 10:00 am

- Introductions and Welcome
- Focus on public speaking
    - Speech Organization
    - Speech Delivery

10:00 am - 10:20 am

- How to deal with audience responses
    - Audience adaptation
    - Create thought within your audience
    - Audience participation

10:20 am - 10:50 am

- Group work/participation--Developing a speech outline/presentation

10:50 am - 11:00 am

- Next steps: Speaking engagements
- Questions/Concerns

Mental Health Association in Hawai'i
200 N. Vineyard Blvd., Suite 300 • Honolulu, Hawai'i 96817
(808)521-1846; Fax 533-6995; E-mail: mha@i-one.com

Mixed Plate Speakers Bureau
Workshop Evaluation II
Wednesday, July 12, 2000 - Diamond Head Health Center

1. What were your expectations before the workshop?

2. Did the presenter meet your expectations? If not, why not?

3. What did you learn from this workshop?

4. Was the presentation well-organized and professional?

5. Was the information you received useful to you?

6. Are there any topics that you wish should have been covered?

7. Any suggestions for further topics to discuss?

Mixed Plate Speakers Bureau

Workshop III

Where: Diamond Head Health Center

Conference Room, 418

When: Wednesday, August 9, 2000

9:00 am - 11:00 am

Snacks will be provided

To register, contact Kaanoi Agunat at 521-1846

Please bring with you to the workshop a
practice speech outline/presentation.

Mental illnesses affect 1 out of 5 individuals!

Over 240,000 adults and children in Hawai'i are affected by a mental disorder.

Let's work together to promote good mental health and reduce the stigma that's attached to anyone with a mental illness...Get screened, get treated, get better!

Agenda

Mixed Plate Speakers Bureau

Workshop III

August 9, 2000 (Wednesday)

9:00 am - 11:00 am

9:00 am - 10:00 am

- Welcome
- Questions concerning Workshop II
- Focus on cultural sensitivity/diversity
- Luncheon with ministers and education director

10:00 am - 11:00 am

- Presentations - 'Speech Outline'
- Next Steps: Speaking engagements

Good mental health represents who we are...mentally, emotionally, verbally, physically, and culturally!

I ka 'olelo no ke ola
'There is life in the word'

Public education and empowerment is the key to advocating the importance of mental health!

Mental Health Association in Hawai'i
200 N. Vineyard Blvd., Suite 300 • Honolulu, Hawai'i 96817
(808)521-1846; Fax 533-6995; E-mail: mha@i-one.com

Mixed Plate Speakers Bureau
Workshop Evaluation III
Wednesday, August 9, 2000 - Diamond Head Health Center

1. Did you feel that your questions and concerns were addressed?

2. Is there anything that you would like to focus on concerning cultural diversity?

3. Was the information given to you helpful?

4. If you presented a speech outline, what anxieties were you feeling, if any?

5. Was the presentation well organized and did the presenter meet your needs?

6. What one thing did you learn from today's workshop?

7. Any suggestions for further topics to discuss?

Mixed Plate Speakers Bureau

Workshop IV

Where: Mental Health Association in Hawai'i

Conference Room 2, Second Floor

When: Wednesday, September 6, 2000

9:00 am - 11:00 am

Snacks will be provided

To RSVP, contact Kaanoi Agunat at 521-1846.

Please bring with you to the workshop

your practice speech outlines

Let's work together to encourage

"ethnic community building"

Understanding cultural competency is the key to advocating mental health services within communities

Agenda

Mixed Plate Speakers Bureau

Workshop IV

September 6, 2000 (Wednesday)

9:00 am - 11:00 am

9:00 am -10:15 am

- Welcome
- Address Questions
- Continue with speech presentations

10:15 am - 11:00 am

- Discuss upcoming church luncheon
- Discuss targeting audiences
- Next Steps: Setting up speaking engagements

The goal is to continue mental health education within our communities.

Let's proceed to lower stigma and strenghthen the idea that seeking treatment is a road to recovery.

Mixed Plate Speakers Bureau
Workshop IV
Speech Outline

I. Welcome
II. Address questions or concerns
III. Continue with speech presentations:
    Charlene, Victor, Sharon, Gordon, Bud
IV. Discuss upcoming church luncheon
    Set up a date and time for luncheon
    Where should we have the luncheon
    What topics should be discussed
V. Discuss targeting audiences
    set up a priority list for targeting audiences
VI. Set up speaking engagements
    Contacts to make
    Who will make the contact
    Setting up a schedule for a buddy system

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200 N. Vineyard Blvd., Suite 300 • Honolulu, Hawai'i 96817
(808)521-1846; Fax 533-6995; E-mail: mha@i-one.com

Mixed Plate Speakers Bureau Workshop Evaluation Tuesday, September 19, 2000 - Diamond Head Health Center

1. What peaked your interest to get involved with the Mixed Plate Speakers Bureau?

2. Was there an organized agenda for all four workshops?

3. Was the presenter's speech format well organized?

4. Did the presenter answer and address all your questions?

5. Was the information given to you helpful?

6. What one thing did you learn throughout the workshops?

7. Would you recommend these workshops to anyone else?

8. Any further comments for future workshops?

CONGRATULATIONS GRADUATE

On this 19th day of September, 2000,

_____has graduated with honors from the Mental Health Association in Hawai'i's Mixed Plate Speakers Bureau. The student has successfully displayed an eagerness to continue advocacy for mental health and the strength and courage to defend mental health services through personal experiences. In an effort to understand cultural competency, he/she has also exhibited the importance of ethnic community building, in a multi-cultural environment. MHA/H thanks you for your continued support in all aspects of mental health. May your journey in life be one filled with joy, happiness, and love.

_____

Student

_____

Kaanoi Kaapana, Facilitator - MHA/H Public Education Assistant

The Mental Health Association in Hawai'i is sponsoring a Community Church Luncheon

Where: Sizzler-Kalihi 1461 Dillingham Blvd.
When: Monday, October 30, 2000
11:00 am - 12:30 pm

We welcome any and all advocates who are willing
to become active participants for
mental health within church committees

To RSVP for this luncheon,
please contact Kaanoi Agunat at 521-1846.

Community outreach is the key to empowering mental health education

Let's work together to promote active participation within church organizations to raise the awareness that good mental health is important

Come spend an afternoon with us,
it will be a lunch worthwhile.

The Mental Health Association in Hawai'i
200 N. Vineyard Blvd. Suite 300 • Honolulu, HI • 96817
521-1846; Fax 533-6995; Email mha@i-one.com

Mental Health Association in Hawai'i

200 N. Vineyard Blvd. • Honolulu, HI • 96817 • 521-1846; Fax: 533-6995

Speaker Request Form

– Please Print –

Organization: _____

Address: _____

Contact Person: _____ Phone Number: _____

Date: _____ Time: _____ Speech Length: _____

Place: _____

Topic Preferred: _____

Expected Number Attending: _____

Audience Background: _____

Age Group: _____ Gender Percentage: _____

Religion/Faith: _____ Ethnic Background: _____

Mental Health Education/Mental Illnesses: _____

_____

Reason for Request: _____

Speaker: _____ Phone: _____
Support Materials: _____
_____
Staff: _____ Number Attended: _____
Comments: _____
_____

Agenda

Mixed Plate Speakers Bureau

October 17, 2000

8:30 am - 10:30 am

8:30 am - 10:00 am

- Welcome
- Discuss Church Luncheon

10:00 am - 10:15 am

- Next targeting audience: Union Workers
- Next steps/Next meeting

Ways for Churches to Support People with Serious Mental Illnesses...
Imagine yourself in the role of persons with the disability. Become aware of attitudes and behaviors that give you dignity and those that offend you.
Organize active outreach to mentally ill persons and their families through your congregation's evangelism committee.

Mixed Plate Speakers Bureau
Church Luncheon - Outline

I. Welcome
II. Sizzler's Luncheon
    A. Church organizations attending
    B. Individual responses
        1. What message are you trying to get across?
        2. What do you hope to achieve throughout this meeting?
        3. If your goals are followed through, what are the next steps?
    C. Come to an agreement as to what should be discussed - develop an agenda
    D. Decide speaking parts for presentation - not one person will dominate
    E. Funding - MHA/H Grant
III. Transportation
IV. Next steps
    A. Follow up with church committees
    B. Next targeting audience
    C. Next meeting

Agenda
Community Church Luncheon

Monday, October 30, 2000
11:00 am - 1:00 pm

11:00 am - 12:00 pm

- Welcome/Introductions
- Introduce the Mixed Plate Speakers Bureau Workshop
- Discussion on Church involvement regarding mental health
    - Families and mental illnesses
    - How churches can help or provide for support groups
- Referrals/Resources for mental health services
- Next Steps

12:00 pm - 1:00 pm

- Luncheon

Ways for churches to support people with Serious Mental Illnesses...
• Respond openly to families who are dealing with mental illnesses. Offer support, concern, help.
• Become informed. Identify local agencies which provide information and services.
• Look carefully at expressions of basic theology so as not to blame or perpetuate the concept of sin, guilt and lack of faith as reasons for mental illnesses.

Cultural Competency Toolkit

CHAPTER 5

The Consumer Involvement Project

NAMI-New Mexico
P.O. Box 3086
Albuquerque, NM 87190-3086
Tel. (505) 260-0154
Fax. (505) 260-0342

Tom Lane, Project Director

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Executive Summary

Discrimination against people with mental illness is rampant in New Mexico, but few consumers in the state are involved in self-help, advocacy and empowerment activities. NAMI-New Mexico (NAMI-NM) proposed to encourage consumer participation throughout the state by offering a series of workshops at seven different sites. In these workshops, participants would determine what consumer-run efforts they wished to undertake in their own regions. NAMI-NM would then provide continuing technical assistance as participants launched these initiatives.

Project Goals

- To offer consumer empowerment workshops at seven sites across New Mexico.
- To encourage workshop participants to start local empowerment projects.
- To provide follow-up technical assistance for these projects.

Introduction

Mental health services in New Mexico have historically promoted "learned helplessness," and although some programs are beginning to shift their basic approach to empowerment models, there is a tremendous need to replicate these programs across the state. New Mexico lacks basic mental health services, and consumers often wait two to three years to qualify for disability benefits and, therefore, for Medicaid. Only a handful of consumers have involved themselves in a decision making-capacity across the state.

New Mexico lacks basic mental health services, and consumers often wait two to three years to qualify for disability benefits and, therefore, for Medicaid.

The impact of managed care on behavioral health services in New Mexico is basically unknown, due to lack of data from behavioral health organizations, but it is generally understood to have been short on service and long on profit. Several providers have closed their doors, case management services are in short supply, and there appears to be a pattern of denied hospitalizations. Advocates for mental health services are focused more on maintaining existing services, and less on expanding or assessing the quality of services.

Public forums

Results of public forums held among six regional clusters of communities indicate that discrimination against people with a mental illness is rampant in New Mexico. Sparse and non-existent services, refusal by insurance companies to pay for necessary medical needs,

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Public forums

Results of public forums held among six regional clusters of communities indicate that discrimination against people with a mental illness is rampant in New Mexico. Sparse and non-existent services, refusal by insurance companies to pay for necessary medical needs,

refusal by employers to hire persons with a mental illness, and reluctance by landlords to rent to people with mental illness are manifestations of this prejudice.

Out of the six clusters, only two had short-term, acute psychiatric facilities for people in crisis. Las Vegas Medical Center is the only long term, psychiatric facility for the entire state; and its purpose is misunderstood by many. In addition to the confusion about who benefits from the services in Las Vegas, clients and family members have complained about difficulty in gaining access to the facility, the numbers of persons turned away, and the expense involved — including the transportation costs and time needed to travel there and back.

Results of public forums held among six regional clusters of communities indicate that discrimination against people with a mental illness is rampant in New Mexico.

In the forums, the expressed need for education about mental illness, treatment, recovery and how to access available services was unanimous. By increasing efforts in these two areas, people believed that other concerns such as housing, employment, transportation and education would be addressed.

The need for ongoing support by the Department of Health and NAMI-NM to develop consumer and family groups was prioritized, as was a central clearinghouse for statewide information and contacts. The clearinghouse was also needed to help provide a safety net for people in crisis, as well as to offer information to providers, clergy, first responders and other community service providers.

More individuals in New Mexico are in jail, (20,200), than are in treatment (20,000). Just one in eight children and one in four adults with mental illness are receiving treatment.

Demographic profile

There are 1.6 million people in New Mexico. Most of the state is rural, and some counties are categorized as frontier due to their sparse population. The New Mexico Department of Health estimates that there are 88,000 adults and 44,000 children who have severe, chronic mental illness in New Mexico.

Sadly, more individuals in New Mexico are in jail, (20,200), than are in treatment (20,000). Just one in eight children and one in four adults with mental illness are receiving treatment. Although the number of persons who are uninsured who have mental illness is not known, one in four of the population statewide lacks health insurance. Thirty of 33 counties in New Mexico are medically underserved.

Poverty rates are equally high - one in three children lives in poverty in New Mexico, and one in four adults. The percentage of persons with mental illness who live in poverty is unknown. The rate, however, is no doubt high due to the forced state of poverty that persons must live in who receive disability benefits.

Project Sites

- Alamogordo
- Albuquerque
- Farmington
- Gallup
- Las Cruces
- Roswell
- Santa Fe

Transportation and lack of medical services are barriers for most people in the state. There are no effective public transportation systems in New Mexico, with the exceptions of limited safe ride services and of minimal bus service in Albuquerque.

With the largest Hispanic/Latino population in the United States (38 percent), 28 Native American pueblos (nine percent), a small African American population (three percent), and a broadly dispersed population of Anglos (50 percent), New Mexico offers a culturally diverse pool of committed individuals who can work together for change.

NAMI-NM works to improve the lives of the over 200,000 citizens in the state who either live with mental illness or who share in the burdens imposed by these diseases.

Program Plan

Through its Consumer Involvement Project, NAMI-NM proposed to stimulate consumer involvement and advocacy across the state by offering a series of consumer empowerment workshops. The workshops would take place at seven sites across the state, and would encourage participants to launch local advocacy projects and consumer services. Once these projects were launched, the Consumer Involvement Project would continue to provide ongoing technical assistance.

Organizational Overview

NAMI-NM is a chapter of the national organization, National Alliance for the Mentally Ill. According to its mission, "advocacy, education and information," NAMI-NM works to improve the lives of the over 200,000 citizens in the state who either live with mental illness or who, as family members and caregivers, share in the burdens imposed by these diseases. NAMI-NM works closely with state agencies and state legislators to develop policies that will enhance the well-being of people with mental illness.

NAMI-NM has a twelve-person board with members from across the state. Seven members are women and five are men, and three members are mental health consumers. Ages range from the early twenties to the mid-seventies, and one member of the board is Hispanic while another member is African American.

NAMI-NM collaborates regularly with a network of 14 NAMI affiliates in New Mexico. Affiliates conduct regular, ongoing support groups and periodic educational meetings. The Family-to-Family program is a twelve-week education course offered to families free of charge. Through the anti-stigma project, NAMI provides public education to community-based groups, businesses, and the criminal justice community. In addition, NAMI trains treatment guardians, judges and physicians in 13 judicial districts on types of illnesses, appropriate treatment, ethics and confidentiality. NAMI also administers jail diversion programs in Albuquerque and in Dona Ana County.

Implementation

The Consumer Involvement Project started with a series of one, two or three workshops offered to consumers at seven different sites across the state of New Mexico. Workshops were advertised through the local media, and Tom Lane, the project director, also contacted local service agencies so that they could invite their clients to participate.

Altogether, some 150 consumers of various ethnicities across the state attended trainings, and materials were provided both in English and in Spanish.

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Says Tom Lane, "we would go into the community, present an overview of what consumer involvement could look like — from drop-in centers to newsletters to becoming involved in advocacy — and then we would encourage people to launch projects on their own."

The next phase of the project entailed providing technical assistance and guidance to consumers as they took Lane up on the challenge to get involved. In many cases, trainees decided to become involved with existing organizations. Various trainees joined local NAMI affiliates and other consumer supporter organizations. Some participants joined state Regional Advisory Committees, and one consumer joined the state Protection and Advocacy Agency's Advisory Council.

Other sites actually launched projects. In Albuquerque and in Las Cruces, members of the Consumer Involvement Project started consumer-run drop-in centers. Another site, as of this writing, is attempting to establish a warm-line. In Farmington, a group produced a video in a Native American language.

Lane also encouraged consumers to network with existing organizations for assistance in project development and management.

In Albuquerque and in Las Cruces, members of the Consumer Involvement Project started consumer-run drop-in centers.

Project Partners

- The Counseling Center
- Counseling Associates
- Life-Link, providing housing support
- New Mexico State Behavioral Health Services
- New Mexico State Division of Vocational Rehabilitation
- Pathways, a psychosocial rehabilitation program
- Santa Fe Community Guidance
- St. Martin's, providing services to the homeless
- University of New Mexico Mental Health Center

Discussion and Conclusion

Launching the Consumer Involvement Project entailed a great deal of "proactive outreach," according to Lane. New Mexico is a largely rural state, and the project director logged in "many, many miles" travelling from one project site to another.

In particular, Lane describes the effort to reach the Native American community as "a challenge...Native providers are on reservations and they can be hard to reach." Nonetheless, Native American consumers did attend the trainings, and the project was also able to include a Native speaking hotline in its resource list.

Although New Mexico's Consumer Involvement Project reached out to the state's Native American and Hispanic/Latino communities, the main focus group of the project, ultimately, were individuals with mental illness. Cultural competency need not extend merely to peoples of various ethnicities. The term applies equally well to consumers of mental health services.

Speaking as a consumer, Lane says that the project was "a nice opportunity for me to shift from receiving services to offering services. It was a big part of my own recovery to shift roles in this way."

Although the Consumer Involvement Project, *per se*, will finish at the end of this grant cycle, it has nonetheless enabled many other consumers to begin to make this shift from receiving services to providing assistance to others in need. Most importantly, the projects initiated at each of the seven sites, thanks to the guidance provided by the Consumer Involvement Project, will continue to serve New Mexico's consumer population.

Cultural competency need not extend merely to peoples of various ethnicities. The term applies equally well to consumers of mental health services.

Additional Resources

Publications

(Hispanic/Latino Americans)

Augenbraum, Harold et al. *Growing Up Latino: Memoirs and Stories.* Boston: Houghton Mifflin. 1993.

Garcia, Jorge and Zea, Maria (editors). *Psychological Interventions and Research With Latino Populations.* Boston: Allyn and Bacon. 1997.

Olmos, Edward (editor). *Americanos: Latino Life in the United States.* Boston: Little, Brown. 1999.

Padilla, Felix. *Latino Ethnic Consciousness: The Case of Mexican Americans and Puerto Ricans in Chicago.* Notre Dame, Indiana: University of Notre Dame Press. 1985.

(Native Americans)

French, Laurence Armand. *Counseling American Indians.* Lanham, Maryland: University Press of America. 1997.

Herring, Roger. *Counseling With Native American Indians and Alaska Natives: Strategies for Helping Professionals.* Thousand Oaks, California: Sage Publications. 1999.

Kelso, Dianne. *Bibliography of North American Indian Mental Health.* Westport, Connecticut: Greenwood Press. 1981.

Narduzzi, James. *Mental Health Among Elderly Native Americans (Garland Studies on the Elderly in America).* New York: Garland Publishers. 1994.

O'Nell, Theresa. *Disciplined Hearts: History, Identity, and Depression in an American Indian Community.* Berkeley, California: University of California Press. 1996.

Organizations

Indian Health Service
Tel. (301) 443-3593
Website: www.ihs.gov

Office of Minority Health
Department of Health and Human Resources
Tel. (800) 444-6472
E-mail: info@omhrc.gov
Website: www.omhrc.gov

CONSUMER INVOLVEMENT PROJECT
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Jointly funded by NAMI New Mexico and the
New Mexico Office of Consumer Affairs

Project Sites

Albuquerque

Santa Fe

Farmington

Gallup

Las Cruces

Alamogordo

Roswell

WORKSHOP 1 PACKET CONTENTS

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2. **Consumer Involvement Project Mailing List form**
3. **Empowerment Toolkit Listing of Documents, Articles**
4. **Center for Mental Health Services Knowledge Exchange Network Consumer Data Base of Interest Mailing List form**
5. **National Empowerment Center listing of Newsletters and Publications produced by Consumers**

Right Side of Folder

1. **CIP Cover Sheet**
2. **Consumer Bill of Rights and Responsibilities**
3. **Skills Worksheet**
4. **Empowerment**
5. **Tom Wolff's Principles of Success in Coalition Building and Promoting Problem Solving**
6. **Co-operation and Problem Solving Worksheet**
7. **Self Help "Why Self-Help Works"**
8. **Self-Help Worksheet**
9. **Consumer Self-help Projects**
10. **Consumer Projects Skills worksheet**
11. **Consumer Projects Community Partners worksheet**
12. **Starting Self-Help Groups: First Steps**
13. **CIP Workshop Survey**

EMPOWERMENT

Empowerment is a complex, multidimensional concept. Although there are similarities to concepts such as self-esteem and self-efficacy, empowerment has distinct differences. Empowerment is a process, not an event. The following is a list of qualities of empowerment.

1. Having decision making power.

2. Having access to information and resources.

3. Having a range of options to choose from, (not yes/no, either/or); a menu of options to choose from

4. Assertiveness

5. A feeling/belief that one person can make a difference (Hopefulness)

6. Learning to think and act differently, seeing things differently, overcoming institutional behavior and learned helplessness; redefining who we are and speaking in our own voice, redefining what we can do, and redefining our relationships

7. Learning about anger, learning more constructive/less destructive ways of expressing anger, learning to get past anger and resentment

8. Feeling of belonging, a part of a group; not feeling alone and isolated

9. Understanding and respecting individual rights and the rights of others

10. Learning to bring about change in one's life, and in one's community

11. Learning and refining skills which are important AS DEFINED BY THE INDIVIDUAL.

12. Willing to be a self identified consumer.

13. Changing others' perceptions of one's competency and ability to be proactive.

14. Self initiated and ongoing growth and capacity to change, to refine one's skills and coping strategies to move towards wellness and recovery

15. Building one's positive self image.

16. Overcoming stigma.

As a process, empowerment for an individual does not mean all these qualities are present; rather that an individual is moving towards developing and using these qualities in living.

SELF HELP

From "Why Self Help Works"

Self Help means that people take an active role in their own recovery, not just be passive recipients of services. Self-help support groups serve a number of functions that can contribute to a person's wellness and recovery. Self-help involves mutual support. People move towards recovery when they reach out and share with others who have experienced common problems.

There are a number of reasons why self-help works.

First, self-help provides a social network.
Many people feel isolated after being diagnosed or after experiencing a traumatic event. People often feel they have been robbed of their humanity. In self-help, people are encouraged to share with others how having a diagnosis has impacted their lives. Membership in a mutual support group helps draw them out and brings them in contact with others who have shared similar problems.

Second, self-help groups give people an opportunity to change their roles from being the *helpee* to the *helper.*
In our society, people who help others are looked up to. Many people feel a sense of satisfaction and increased self-esteem when they are given the opportunity to help another person.

Third, these groups give people the opportunity to share with others ways that they have successfully coped with symptoms. Learning that they can still have a life even though they have symptoms gives people hope.

HOPE IS AN ESSENTIAL INGREDIENT TO RECOVERY!

Fourth, they provide positive role models.
Professional have an important role in the recovery process, but they can't always act as role models. Most probably haven't had to cope with symptoms, or with the stigma of having a mental illness diagnosis, or with the myriad of other problems those in recovery face. Group members can't really model therowntheir own behavior or lives after that of the professional.

They can, however, model their behavior following someone who has experienced the same kinds of problems they have.

Finally, self-help gives meaning to people's lives.
They attend because they choose to attend, not as a condition of a treatment plan. They are able to design a plan for their lives based on their own choices and preferences, not on the judgment of a provider.

CONSUMER SELF-HELP PROJECTS

Consumer self-help projects can address many of the needs of consumers. If we believe as consumers, we are best qualified to meet our own needs then we have the responsibility to figure out ways to do this.

Here's a list of consumer-run services and activities. There may be projects, services, and supports not listed here; are there others you can think of?

⇒ Peer counseling
⇒ Speakers' bureaus
⇒ Creative writing classes
⇒ Advocacy (self advocacy and advocacy for others)
⇒ Information and referral services
⇒ Outreach programs (like UNM's Peer Bridger Program)
⇒ Housing development
⇒ Employment opportunities
⇒ Loan funds
⇒ Roommate matching services
⇒ Newsletters
⇒ Outings, trips, social events
⇒ Dances
⇒ Self-help groups (like DMDA, NAMI consumer support groups, AA, DTR)
⇒ Stipend programs
⇒ Leadership training and skills development (Leadership Academy)
⇒ Drop in Centers
⇒ Clubhouses
⇒ Information Clearinghouses
⇒ Peer case management
⇒ Crisis services/respite care
⇒ Warmlines
⇒ Consumer-run businesses
⇒ Consumer advisory boards

Once a project or service has been identified, and a group of consumers has agreed to

1. Use personal skills and talents to work on the project
2. Develop an attitude of "group empowerment" using qualities discussed earlier
3. Set achievable goals using action and group resources
4. Decided to commit time and effort, to be persistent in working on the project

Then, a **Plan of Action** can be developed. Each member of the project group should offer skills and talents, time, and an attitude of co-operation. Strategies will need to be discussed to use in the **Plan of Action.** Always remember that a little progress is better than no progress at all.

Cultural Competency Toolkit

CHAPTER 6

The Mental Health/ Aging Advocacy Project

The Mental Health Association of
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1211 Chestnut Street, 11th Floor
Philadelphia, Pennsylvania 19107
Tel. (215)751-1800
Fax. (215) 636-6300
Website: www.mhasp.org

Tom Volkert, Project Director

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Executive Summary

Philadelphia has one of the highest percentages of older adults in major cities in the United States, yet only serves approximately two percent of the older adults who need mental health services. The Mental Health Association of Southeastern Pennsylvania (MHASP) proposed to address this great disparity by building upon its Mental Health/Aging Advocacy Project, first initiated 1998. MHASP planned first to train elderly consumer/caregiver advocates and then to approach providers and insurers to demand that appropriate services be made available for older adults.

Project Goals

- To develop materials and train at least five older adult leaders.
- To contact senior groups and offer presentations on mental health aging and advocacy.
- To organize and conduct follow-up with small group sessions.
- To follow up with monthly contacts to these small groups.
- To advocate for accessible and appropriate mental health services.

Introduction

More than five million Americans age 65 and older—nearly one in six—suffer from the serious, persistent symptoms of depression, while another million have major clinical depression, an immobilizing disorder that can lead to suicide. In fact, from 1980 to 1992, suicide rates rose by nine percent among all Americans 65 and older and by 35 percent among those aged 80 to 84. The suicide rate of the elderly currently stands at an alarming 21 percent, the highest rate for any age group in the United States. Every day, 17 older Americans take their own lives. Only a small percentage of those deaths are believed to indicate a well-reasoned escape from an incurable, debilitating illness.

At the same time, the number of elderly people in America is growing. In 1990, one in 25 Americans was 65 and over; by 1994, one in eight fell in this category. This is a pattern of growth that will continue well into this century.

Between 18 and 25 percent of elderly persons in general—and a staggering 66 percent of nursing home inhabitants—experience some form of mental illness.

This means that the number of older Americans who have mental illnesses will also grow. Between 18 and 25 percent of elderly persons in general—and a staggering 66 percent of nursing home inhabitants—experience some form of mental illness. These range from depression, anxiety, bereavement adjustment problems and substance abuse to schizophrenia, personality disorders, paranoia, compulsive behaviors and dementia.

However, older adults with mental illness tend to be unrecognized, undiagnosed and untreated. Elders account for only seven percent of all inpatient psychiatric services, six percent of community mental health services and nine percent of private psychiatric care. In fact, less than three percent of all Medicare reimbursement goes to psychiatric treatment.

The sad irony is that most mental illness in older adults is treatable. For instance, depression studies have shown that a combination of medication and therapy can result in significant improvement for 80 percent of older adults who receive treatment.

Serving elderly persons with mental illness has not been a high priority for most mental health agencies.

Serving elderly persons with mental illness has not been a high priority for most mental health agencies. Services are usually fragmented among the health, mental health, and human services agencies, resulting in problems in providing coordinated and appropriate services. In addition, very few professionals in mental health agencies are specifically trained to serve this population.

In addition, many obstacles—including physical disabilities, social isolation, lack of transportation, the stigma attached to psychiatric care, a fractured mental health system that requires a 50 percent co-pay for outpatient mental health treatment and the complex nature of mental illness in older adults—negatively impact attempts to serve elderly persons with mental illness. Older adults of minority cultures face the additional barriers of poverty, language, or racial, cultural or ethnic bias.

A half-million plus individuals over 65 live in Southeastern Pennsylvania, 33 percent of whom represent minority populations. Of that group, almost 30,000 have incomes low enough to make them eligible for Medicaid.

A half-million plus individuals over 65 live in Southeastern Pennsylvania, 33 percent of whom represent minority populations. Of that group, almost 30,000 have incomes low enough to make them eligible for Medicaid. The 1990 census of Philadelphia showed 19 percent of the population to be over 65. Yet a recent study by the Philadelphia Office of Mental Health showed that out of 55,000 people served in 1998, only 3,000 were older adults.

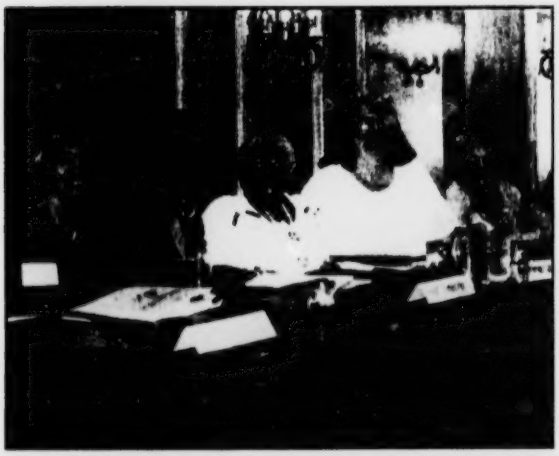
Program Plan

To help overcome these barriers, the Mental Health Association of Southeastern Pennsylvania (MHASP) saw the need for an informed and organized constituency—including older adult consumers and their caregivers and family members—to advocate for the services required. In order to advocate for appropriate and accessible services for all older adults in the area, MHASP proposed a two-pronged effort to reach out and empower older persons and their friends to educate mental health service providers through its Mental Health/Aging Advocacy Project.

First, the program would contact older adults, caregivers and advocates in order to address issues of ageism, mental health stigma, and lack of services. MHASP would teach these older adults how to get help and how to join with other people to develop a voice advocating for improved services. The project would form an active network of older consumers and caregivers to implement the new skills.

MHASP proposed to teach older adults how to get help and how to join with other people to develop a voice advocating for improved services.

Second, the project would also collaborate with the Delaware Valley Mental Health/Aging Advocacy Committee to establish systematic contact with providers, insurers, government officials and others who serve the elderly; would raise awareness of the need to provide culturally competent services to older adults; would provide relevant information on mental health and aging; and would urge all providers to develop mental health and aging committees. Specifically, MHASP proposed to have consumers/providers make presentations to the County Offices of Mental Health in two counties and meet with at least two major insurance companies to succinctly present a program of mental health needs of the elderly.



Older adults Madelyn Glover and Eleanor Campbell present as part of a panel on Mental Health and Aging in June 2000.

MHASP's Mental Health/Aging Advocacy Project was already active in the North Philadelphia region at the time of this grant proposal, and they proposed to expand their activities to a five-county region with the help of NCSTAC funding.

Organizational Overview

MHASP is an advocacy, service and education association founded in 1951 to help improve the lives of people with mental illnesses. Its president and chief executive officer, Joseph A. Rogers, is nationally recognized as a leader in the consumer movement.

MHASP employs more than 250 people, many of whom are consumers of mental health services. It has been actively involved in providing community-based support programs and services for people with mental illnesses since 1984 and today operates more than 30 such programs in Philadelphia and its surrounding counties.

MHASP is an affiliate of the National Mental Health Association, and supports its activities on behalf of people with mental illnesses. MHASP is also a member agency of United Way of Southeastern Pennsylvania.

Implementation

The Mental Health/Aging Advocacy Project's efforts were prodigious in this grant cycle. Altogether, MHASP trained seven older adults to be mental health advocates, and four of these individuals were themselves consumers.

Further, MHASP met with eight senior center coordinators in the Philadelphia area and in Delaware County. They developed training materials, gathered information on continuum of care, set up trainings for drop-in center staff, and also developed a legislative action page on their website at www.mhaging.org. They offered two day-long trainings, and they visited three senior centers and offered large group presentations. MHASP also arranged monthly gatherings of seniors and senior leaders.

MHASP developed training materials, gathered information on continuum of care, set up trainings for drop-in center staff, and also developed a legislative action page on their website at www.mhaging.org.

MHASP further implemented two sets of five-day advocacy trainings at senior centers, with some commendable outcomes: On the fifth day of these trainings, participants were asked to write an advocacy letter. Locally, one of the hot issues at the time of the trainings was the need to establish a geriatric specialist for district clinics. Participants wrote on this subject to the local commissioner of health, who later moved to establish just such a position.

MHASP's senior leaders moved quickly into the role of public advocacy. Three older adults trained by MHASP testified at the Office of Mental Health yearly public hearing in Philadelphia, while another project participant spoke out at a similar meeting in Delaware.

Six Mental Health Problems of Older Adults

1. Depression—occurs in 5-30 % of older adults
2. Suicide—17 older adults take their lives each day
3. Anxiety—occurs in 10-20% of older adults
4. Dementia—10% of older adults have dementia
5. Alcoholism—occurs in 5-10% of older adults
6. Misuse of medication—thought to be common

Discussion

Primarily, Tom Volkert, the project director, reported two types of barriers in his attempts to recruit and educate senior leaders. The first were some of the typical effects of aging, "such as difficulty in hearing, writing, and reading, which made it difficult to engage older people in advocacy work." Secondly, Volkert also found that his presentations had to compete with other senior center activities, such as bingo, and it was not always easy to persuade people to give up their favorite pastimes in order to attend a presentation on mental illness.

The main trick to overcoming the first of these barriers, said Volkert, was "being persistent—reading materials to people, moving away from written materials, (or engaging in) role playing." According to Volkert, "these strategies seem to work." He also found it worthwhile to try "to make 'mental health jargon' more simple, understandable and clear."

Similarly, attrition was a challenge Volkert faced as some senior leaders had to step back from their advocacy roles due to health problems. Consequently, the Mental Health/Aging Advocacy Project had to be adept at working with changeover in leadership.

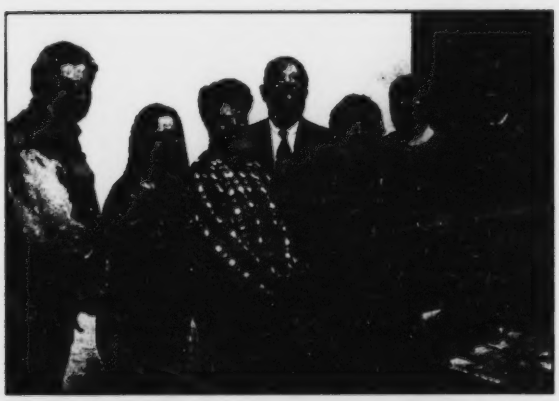
Attrition was a challenge, project director, Tom Volkert faced as some senior leaders had to step back from their advocacy roles due to health problems.

In order to pique seniors' interest in learning about mental health, Volkert chose to focus on topics that were of particular interest to all seniors—not just those with mental health problems. For example, said Volkert, "the topic of prescription meds has been a hot topic, and people have become very engaged in that issue."

In sum, Volkert learned to "adapt the mental health message to older adults and work on their time-line."

Conclusion

Many mental health needs of the elderly continue to go unmet, and MHASP's Mental Health/Aging Advocacy Project will persevere in addressing these problems. In the future, Volkert plans to visit HMO's together with senior leaders to discuss some of the inequities in mental health provisions for elderly patients. He anticipates that this initiative will be "confrontational and difficult," but he is prepared to take the step nonetheless.



A delegation of consumers and advocates meet with State Senator Tilghman to discuss mental health and aging issues.

Additional Resources

Publications

Fogel, Barry S., Furino, Antonio and Gottlieb, Gary L. *Mental Health Policy for Older Americans: Protecting Minds at Risk.* Washington, D.C.: American Psychiatric Press. 1990.

Gatz, Margaret (editor). *Emerging Issues in Mental Health and Aging.* Washington, D.C.: American Psychological Association. 1995.

Knight, Bob. *Outreach With the Elderly: Community Education, Assessment and Therapy.* New York: New York University Press. 1989.

Smyer, Michael A. and Qualls, Sara H. *Aging and Mental Health (Understanding Aging).* Malden, Massachusetts: Blackwell Publishers.1998.

Tice, Carolyn J. and Perkins, Kathleen R. *Mental Health Issues and Aging: Building on the Strengths of Older Persons.* Pacific Grove, California: Brooks/Cole. 1996.

Zarit, Steven H. and Zarit, Judy M. *Mental Disorders in Older Adults: Fundamentals of Assessment and Treatment.* New York: Guilford Press. 1998.

Organizations

American Association for Geriatric Psychiatry
7910 Woodmont Ave.
Bethesda, MD 20814-3004
Tel. (301) 654-7850
Fax. (301) 654-4137
E-mail: info@aagponline.org
Website: www.aagpgpa.org

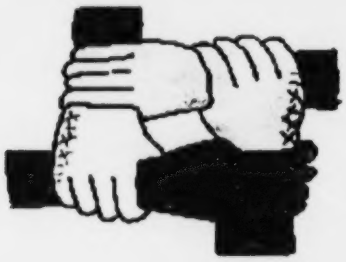
United Seniors Health Cooperative
Suite 200
409 Third Street, S.W.
Washington, D.C. 20024
Tel. (202) 479-6973
Fax. (202) 479-6660
E-mail: ushc@unitedseniorshealth.org
Website: www.unitedseniorshealth.org

Internet Resources

Medicare: The Official U.S. Government Site for Medicare Information. www.medicare.gov/

Mental Health Association of Southeastern Pennsylvania: Mental Health and Aging. www.mhaging.org

KNOWLEDGE, SUPPORT & ACTION CAN MAKE THE DIFFERENCE



- **Is someone you know experiencing the blues and can't quite get past them?**
- **Has someone you know experienced significant loss and not sure where to turn for help?**
- **What are the obstacles that keep people from getting help?**
- **How can I really make a difference?**
- **Want to go from "surviving aging to thriving" as you age?**

Come and find out! Join Tom Volkert, Director of Mental Health/Aging Advocacy of the Mental Health Associaion to find out about some <u>FREE</u> workshops.

FRIDAY, MARCH 2 AT 10:30 AM

Sponsored by Southwest Senior Center and the Mental Health/Aging Advocacy Project of the Mental Health Association of Southeastern Pennsylvania

OLDER ADULTS AND MENTAL HEALTH

Right now, 20% of the population of Philadelphia is 60 years old or above. This number will increase in the coming years.

Most older adults enjoy good mental health. Depression, anxiety, dementia and other mental illness are not part of normal aging. Yet between 18 and 25% of older adults suffer with mental illnesses like depression, anxiety, and dementia. Most incidents are treatable and people can feel better. Yet only a small number of older adults get help.

There are several reasons why older adults don't receive the help they need:

- Many older adults are ashamed or embarrassed to talk about mental health or get help for themselves or their loved ones.
- Quality mental health care for older adults is not always available or affordable.
- People think that some problems that older adults face are not treatable but part of getting old.

WHAT WILL HAPPEN IF WE IGNORE THESE NEEDS?

The results of not treating depression, anxiety, substance abuse and other mental health problems are not cheap! First, there is the personal and family suffering that is priceless. In addition, mental health problems can mean an increase risk of physical problems, increase health costs, further deterioration in the ability to function, and death.

The good news is that the treatment of Depression in older adults is effective 80% of the time.

WHAT IS THE MENTAL HEALTH/AGING PROJECT?

The purpose of the project is: to increase awareness about older adults and mental health issues, to help senior mental health consumers and caregivers get the help they need and to advocate on a local, state and national level to improve the mental health services available to older adults.

HOW IS IT HELPING PEOPLE?

The project works with consumers, caregivers, families and friends of older people in several ways:

- Making presentations at Senior Centers, Churches, Synagogues, etc. about mental illness issues
- Providing advocacy training and support groups for those trying to get help from the mental health/substance abuse system

- Helping advocate with individuals to get the help they need
- Working to educate the public on the need to develop more accessible services to older adults
- Working to make mental health services more accessible and appropriate for older adults
- Developing a website: www.MHAging.org that helps consumers and caregivers find mental health resources and advocate for a better system

You can learn more about our project on our website: www.MHAging.org

DO YOU WANT TO JOIN?

There are a number of ways that you can join our work.

- Learn more about mental health and aging
- Suggest a presentation to your senior group
- Join or start a Senior Advocacy Committee
- Become part of the Senior Advocacy network

Contact :Tom Volkert
1211 Chestnut St.
Philadelphia, PA 19107
(215) 751-1800
tvolkert@ mhasp.org

A project of the Mental Health Association of Southeastern Pennsylvania.

MH&A Mental Health and Aging

Helping older individuals enjoy the harvest of life

MH&A Mental Health and Aging

Online at: www.mhaging.org

Outline of the Five-session Mental Health/Aging Advocacy Training

Session One: "Getting to Know Us"- Understanding Aging and Mental Health

This purpose of this session is to help the group feel comfortable with talking about mental health in the group, to give some background material about aging and mental health, and encourage members to be aware of signs of mental health/substance abuse problems. It concludes with a discussion on how to maintain wellness of mind and body.

Session 2: "What Keeps People From Getting the Help They Need?" – Barriers to Mental Health Services

The purpose of this session is to name the obstacles that keep people from getting mental health/substance abuse services, to describe advocacy and to consider some of the personal attitudes needed for self-advocacy. It also presents tips on talking with their primary care physician and shows a powerful video about how we need to be aware of the subtle signs of depression.

Session Three: "Getting the Care That You Need and Deserve" – Knowing How the System Works

The purpose of this session is to learn more about self-advocacy skills with regard to Medicare and insurance. A story is presented of someone in need of services that are being denied by her health insurance. The session emphasizes knowing about their Medicare rights and the appeal process, tips on dealing with Medicare, and what resources are available in the community to assist in getting the help that people need.

Session Four: "What is Advocacy is, What it isn't" – How You Can Make a Difference For Yourself and Others

The purpose of this session is to describe the values of advocacy, learn how to use self-advocacy skills with regard to medication, and to practice system advocacy. Participants will write a letter to a legislator about an issue that is affecting mental health services.

Session Five – "Making the System Work for Older Adults" – Tapping the Power of Older Adults to Change the Future

This final session identifies some of the larger issues that are affecting mental health services for older adults, invites them to be part of an ongoing network of senior groups that are advocating for change and concludes the training.

Mental Health/Aging Advocacy Project is part of the Mental Health Association of Southeastern Pennsylvania, 1211 Chestnut Street, Philadelphia, PA 19107 215 751-1800, ext. 266

Normal Aging Process

Body - Slows down

- reflexes are slower	Driving Slower
- Sensory changes hearing /vision loss	Glasses/ hearing aides
- Smell and taste loss	Appetite may not be as good
- Muscle strength/endurance/	Coordination not as good
- Height	Shorter
- Bone changes and joint changes	Slower walking
- Appearance	More wrinkles/ gray
- Susceptible to some diseases: cardiovascular, respiratory, arthritic	heart attacks, arthritis

Mind – Slower reacting

- Intelligence remains the same	Ability to see patterns slows
- Ability to retrieve knowledge slows	Longer to answer
- Minor Forgetfulness	Can't remember keys
- Emotional- Less impulsive/anxious	Mellow
- More emotionally complex	Can have a range of responses to events
Greater flexibility in behavior/social skills	Less stereotypical about some issues

What doesn't change with Age ?

- Personality
- Person's knowledge base and vocabulary
- The ability to learn new information

Not Normal Aging

Body

Falling down

Unexplained weight loss

Inability to sleep

Lack of energy

Mind

Significant changes in mood

Changes in personality

Changes in reasoning and thinking like the loss of recognition of familiar people or objects

Handout B

MH&A Mental Health and Aging

www.mhaging.org

How do I know if I could benefit from Professional Mental Health Services?

The following is a list of questions that can help you determine whether you or someone you care about could use some professional help. All of the questions represent some important part of thinking or behavior that can be addressed through mental health services. A yes answer to one or more questions may suggest that you could benefit from a mental health assessment or intervention.

- Have I noticed a change in my behavior?
- Do I feel more disoriented, confused, or easily agitated than usual?
- Do I feel strong and repeated concerns about death or dying?
- Have I not been taking my medication for mental health problems as it is prescribed?
- Do I find myself arguing a lot with my family and my neighbors?
- Do I find myself in a bad mood more than usual?
- Do I avoid being with people and feel anxious when I talk with people?
- Do I feel pains and aches that don't have any medical basis?
- Have I been drinking excessive amounts of alcohol or taking drugs?
- Do I have more trouble functioning in the community than in the past?
- Do I find myself wandering around not sure of what I am doing or where I am going ?
- Have I not been eating or caring for my personal hygiene ?
- Am I suspicious of others including my friends and family?
- Do I find no pleasure in doing things that I used to enjoy a great deal?
- Do I feel hopeless or worthless?
- Do I feel more nervous and worried than usual without any reason?
- Do I feel that it doesn't matter if I live or die?

The Mental Health Association of Southeastern Pennsylvania at 215-751-1800 ext. 226.

Six Mental Health Problems of Older Adults

1. Depression : A complex medical illness and/or reaction to loss in life.

- It's persistent symptoms interfere with normal daily functioning.
- Occurs in 5-30% of older adults

Unique to Older Adults

- There are more physical complaints (stomach aches, head aches body pains, problems with sleep) which may be signs of depression.
- Many older adults have physical illnesses and their chances of developing depression as a result of illness, pain or disability increases in later life.
- Older adults may deny being depressed or needing help.
- Sometimes depression symptoms are mistaken for dementia.

Treatment: a combination of medication and talk therapy. 80% that are treated report relief in their symptoms.

2. Suicide: Taking of one's own life

- Older Adults have the highest completed suicide rate of any age group, 17 per day.
- Older white males complete more suicides than any other age group.

Unique to Older Adults

- Older adults usually do not commit suicide impulsively.
- Attempts are disguised or underreported.

Treatment: Counseling and medical care or hospitalization are available depending upon the underlying cause.

3. Anxiety : a person is unable to cope with normal fears and worries that interfere with daily living.

- 10-20% of adults over 65
- Takes the form of panic attacks, physical symptoms, phobias, or general anxiety about living.
- Involves unrealistic or excessive anxiety about life circumstances

Unique to Older Adults

- Some physical signs may be confused with the signs of a heart attack, stroke or other medical emergencies.

Treatment: Medication and talk therapy are effective. Behavioral therapy is effective in teaching people how to respond to situations that formerly caused overwhelming anxiety.

4. Dementia: a loss of mental abilities caused by the death or degeneration of brain cells that is not part of normal aging.

- 10% of older adults suffer from dementia
- 60% have Alzheimer's, 40% have vascular dementia
- Involves deterioration of certain functions: Amnesia, Aproxia (impairment of learned movements), Agnosia (failure to recognize what is seen), and Aphasia (inability to talk)

Unique to Older Adults

- The majority of dementia victims are older.
- The likelihood of developing dementia increases with age.

Treatment: For Alzheimer's no treatment is available. For vascular Dementia, there is no cure but further strokes can be prevented with medication.

5. Alcoholism: an illness in which there is abuse and/or dependence upon alcohol.

- Between 5- 10%
- Older men are 2-5 time more likely to abuse than older women

Unique to Older Adults

- 1/3 of alcoholics develop the disease after age 45.
- Adults are more affected by less alcohol because of slower metabolism and use of other medications.

Treatment: Various approaches depending on the psychological and physical condition of the person.

6. Misuse of medication: When someone takes prescribed medications in the incorrect number contrary to the doctor's order.

- Combining prescription and over-the counter medications without consulting a doctor can result in misuse.

Unique to Adults

- Older persons take more prescription and over-the counter drugs than any other group.

- Misuse can lead to serious side effects, illness or death.

Treatment: Professional assistance may be needed for people who have an underlying illness, such as depression. People who have memory problems may need reminders like charts and pill dispenser.

MH&A Mental Health and Aging

Mental Health Aging Advocacy Project- 1211 Chestnut Street,
Philadelphia PA 19107 215-751-1800, ext. 266

BEING A PART OF THE SENIOR OUTREACH PROJECT

1. Be aware of your own/ others mental health.
2. Have a circle of friends that will check on you and help if needed.
3. Know where to get help if needed.
4. Know what your mental health insurance coverage and rights are.
5. Be part of the Senior Advocacy Team
6. Write out your questions before you see the doctor. Demand that your doctor answer all of your questions to your satisfaction. Bring someone with you.
7. SPEAK OUT ! Be part of the senior writing network. It will pay off.
8. Live every day as if it were your first.

Sponsored by
The Mental Health Association of Southeastern Pennsylvania
1211 Chestnut Street, Philadelphia, PA 1910
215-751-1800, ext. 266. FAX: 215-636-6312
Internet: www.mhasp.org Email: tvolkert@mhasp.org

Common obstacles faced by older adults - Form D

Sometimes, when we face an obstacle, we have a passive response, and sometimes we have an aggressive response. Other times, we respond in a constructive manner. On the left are some common obstacles. Think back to times you've faced these obstacles, or imagine yourself facing these obstacles. What would your reaction be like? Put an "X" in the proper place along the line

Example: You wanted to change your medications or stop taking a certain medication and were told you could not do so.	X passive constructive hostile
You wanted to change your doctor but were told that you could not do so.	passive constructive hostile
You were told by your doctor that your age was the cause of sleep problems and to stop complaining.	passive constructive hostile
You wanted to stay longer in a hospital but were told that you had to leave.	passive constructive hostile
You called paratransit but they came an hour late to pick you up.	passive constructive hostile
You were made to feel bad by unsupportive family members.	passive constructive hostile
You were told that if you can't take care of your house you will have it taken from you.	passive constructive hostile
You wanted another visit with a specialist but your insurance told you that you couldn't.	passive constructive hostile
You were involuntarily hospitalized.	passive constructive hostile
You wanted to talk with a pastor about personal issues but were ignored.	passive constructive hostile
You received the wrong amount of medication from the pharmacist.	passive constructive hostile
Your medications were changed and you didn't understand why.	passive constructive hostile
You were pressured to buy some product that you didn't think you needed.	passive constructive hostile

Add up your score_____.

Attitudes necessary for self-advocacy are:

- **belief in yourself**
- **being assertive**
- **managing your anger**

National Mental Health Consumers' Self-Help Clearinghouse
Form B

BEST COPY AVAILABLE

Self-Assessment Tool - Form E

Think about some of the obstacles that you've faced recently. How do you react to obstacles? This isn't a test and there are no "right" answers! The purpose of this exercise is to help you learn more about yourself.

1. *Check one.* When I face a problem, I usually:

   - ❑ Blame myself
   - ❑ Blame others
   - ❑ Blame the system
   - ❑ Blame no one
   - ❑ Investigate who's responsible

2. *Check all that apply.* When I face a problem, I usually:

   - ❑ Feel sad or discouraged
   - ❑ Feel angry
   - ❑ Can't concentrate
   - ❑ Fixate on the problem
   - ❑ Try to find solutions

3. *Check one.* When a doctor or government employee tells me something, I usually:

   - ❑ Believe the person
   - ❑ Ask someone else
   - ❑ Look for information on my own

4. *Check all that apply.* I discuss problems with:

   - ❑ Doctors, nurses, and therapists
   - ❑ Friends and/or family
   - ❑ A case manager or other advocate
   - ❑ Peer groups

5. *Check all that apply.* I find the following helpful:

   - ❑ Written materials from Social Security, Medicare, or Medicaid
   - ❑ Written materials from consumer groups or other advocacy groups
   - ❑ Written materials from my doctor
   - ❑ Information on the Internet
   - ❑ Books from the bookstore or library

National Mental Health Consumers' Self-Help Clearinghouse
Form D
Page 1 of 3

6. *Check all that apply.* When I face a problem, I make lists of:

- ❑ Important facts
- ❑ People to contact
- ❑ What I want
- ❑ What I will do

7. *Check all that apply.* When I use the phone to solve a problem:

- ❑ I am nervous.
- ❑ I am confident.
- ❑ I lose my temper or shout.
- ❑ I give up if my calls are not returned.
- ❑ I sometimes ask to speak to a supervisor.

8. *Check all that apply.* When I need to write a letter:

- ❑ I am nervous.
- ❑ I am confident.
- ❑ I ask for help in writing the letter.
- ❑ I ask a friend to proofread the letter.
- ❑ I send copies to other people.

9. *Check all that apply.* When I schedule a meeting to solve a problem:

- ❑ I am nervous.
- ❑ I am confident.
- ❑ I lose my temper or shout.
- ❑ I have a written plan for the meeting.
- ❑ I bring a friend along.
- ❑ I send a letter afterward.

10. *Rank 1st, 2nd, and 3rd.* My top three choices for resolving a problem are:

1. Using the phone _____
2. Writing a letter _____
3. Scheduling a meeting _____

11. *Check all that apply.* If a problem isn't solved right away:

- ❑ I give up.
- ❑ I get angry.
- ❑ I ask someone for help.
- ❑ I try to get more information.
- ❑ I talk to people's supervisors.

12. *Check all that apply.* When someone makes a promise to me but doesn't keep it:

- ❑ I give up.
- ❑ I get angry.
- ❑ I contact the person.
- ❑ I contact the person's supervisor.

Assessing the Care You Receive

Always remember you have the right to be treated with dignity and respect. You are the most important expert about yourself. Any professional should encourage you to tell them what your problems are and what it is you think you need from them.

In trying to figure out if you are pleased with the care you are receiving from a doctor or other kind of therapist it is important for you to use your own judgment and common sense or instinct in deciding for yourself if you are pleased. It is OK to evaluate how you think you are being treated by a professional. You may want to ask to yourself:

Is this professional understanding me and being helpful to me?

In trying to determine helpfulness by your doctor or therapist, the following questions may help you or your family evaluate what kind of care you are receiving.

Prior to your visit with the professional

Take a list of questions with you that you want to have answered by the professional.

If possible, and if you feel comfortable, arrange to take a trustworthy family member or friend with you to your appointment.

During your visit

Either yourself or the person accompanying you may want to write down the instructions the professional gives you. Make sure you understand what the doctor is saying to you and what he or she wants you to do.

Consider whether the professional is listening to you. Are you encouraged to tell him/her what your problems are?

Does she/he talk to you in a manner that helps you feel comfortable?

Does he/she explain what they think is going on with you and what might be the best treatment for your problem?

Are you permitted to ask additional questions about the recommended treatment?

If the doctor wants you to take medicine, does she/he explain how the medicines work and what benefits the medicine may have?

Are side effects of medications explained to you?

Does the doctor suggest or discuss any different kind of treatments that are available or other things you can do yourself that might help you?

Are any pitfalls of treatment or medications explained to you?

Does he/she give you choices about what can be done to help you with your problem?

Is your doctor available by telephone and are you made to feel comfortable to call the doctor by telephone?

Are your questions encouraged and are they answered in a way that satisfies you?

If a referral to another doctor, clinic, hospital or agency is made, is there any help offered to you in following through with the referral?

Do you feel comfortable asking your doctor to have a second opinion about your treatment?

Other important issues to consider

If you have more than one doctor, make sure they all know what is happening to you.

Try to have one doctor be in charge or know about all of the treatments and medications you are receiving.

Always ask any specialist to notify your family doctor about what problems they diagnosed and the treatment they are recommending to you.

Some drugs interact with other drugs and may be harmful when used together, therefore, each doctor should have a list of all your medications. Utilizing only one pharmacist is also helpful to you since a pharmacist also lets you know if a new medication will be potentially harmful if used with your current list of medications.

We would like to thank Marc Zisselman M.D. of the Philadelphia Geriatric Center for his help in developing these guidelines.

Mental Health/Aging Advocacy Project
Mental Health Association of Southeastern PA
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Handout G

Medicare managed care treatment denials

Pat's story

Pat is retired and has lived alone for two years, ever since Pat's spouse passed away. Despite participating in activities at a local senior center, Pat has been "feeling down" for much of these two years. Recently, Pat has not been sleeping or eating as well as usual. Also, Pat has been forgetting to take prescribed medications, including high blood pressure medication.

Worrying about this forgetfulness, Pat went to the doctor. Pat had chosen to have Medicare coverage through a health maintenance organization (HMO), so Pat has a doctor assigned by the HMO.

After speaking with Pat for a while, the doctor said, "I'd like to give you a quick test." It wasn't a medical test—just a set of questions. Afterwards, the doctor said, "I think that the reason you've become forgetful and are having trouble sleeping and eating might be that you're depressed. I want you to go talk to someone about it."

Pat was worried, but the doctor was reassuring, saying, "I'm not saying you're crazy, but I think that a psychologist could help make you feel better." Pat's doctor wrote out a referral to a psychologist, and Pat made an appointment with a psychologist who was part of the HMO network. During Pat's first visit, the psychologist explained that she'd try to help Pat work through the feelings of depression.

During the same visit, the psychologist also told Pat that because she is part of the HMO network, she could meet with Pat four times. After that, she would need to get approval from Pat's HMO. For the first four therapy sessions, Pat would have a co-payment of $15.00.

Pat and the psychologist decided that Pat would come to see her each Monday for the next four weeks. After meeting with the psychologist twice, Pat was starting to feel a little better. Although it was difficult to talk about losing a loved one, it felt good to work through some of the sadness.

At the fourth therapy session, the psychologist told Pat that she would send in a recommendation for four more therapy sessions and would call in a few days to schedule the appointments if they were approved.

That week, Pat's psychologist called and said that the HMO had not approved additional therapy sessions. She had recommended more sessions because she thought that continuing to talk about losing a spouse might help Pat deal more effectively with the feelings of depression. However, the HMO had told her that they felt that because Pat was feeling better, the therapy had already achieved success and therefore could be discontinued.

Pat was confused—this seemed terribly unfair. The psychologist explained that HMOs often try to encourage short-term therapy, which in her opinion, only resulted in short-term results. She explained that Pat's options would be to appeal the HMO's decision, or that she could see Pat at her private practice. However, this would cost $110.00 per session because it would not be covered by insurance. With Pat's fixed income, this would create a major hardship.

Analyze the problem
What are the facts significant to Pat's appeal of the HMO's decision?

Formulate a solution
Class discussion: Why should you use self-advocacy rather than relying on your doctor or therapist?
Class discussion: If MCOs are primarily concerned with costs, how can Pat use this to his advantage?

Written communications
Fill in the missing sections of the appeal form on the following page.

Handout H

An overview of self-advocacy skills

Analyze the problem

Ask yourself:

1. What is the problem?
2. Can I break it down into smaller problems?
3. How is the problem harming me?
4. Who is responsible for the problem?
5. Is someone violating a law, policy, or procedure?

Formulate a solution

Ask yourself:

1. What do *I* want to happen?
2. Who will I approach?
3. What are the strengths of my case?
4. What does the other side have to gain?
5. What is my action plan?

Communications (general)

Ask yourself:

1. Are there any formal procedures to follow?
2. What type of communication (written, phone, in-person) is most appropriate?
3. What type of communication am I best at/most comfortable with?

Written communications

1. Follow standard format.
2. Explain what you want.
3. Include documentation.
4. Explain reasons action is needed.
5. Explain steps you've taken.
6. Set timeline for response or action.
7. CC to the right people.
8. Watch your tone.
9. Keep a copy.
10. Proofread!

Verbal communications

On the phone and in person:

1. Plan your agenda.
2. Practice what you'll say.
3. Have a support person.
4. Be assertive.
5. Don't attack or insult.
6. Listen *actively* to the other person.
7. Negotiate for what you want.
8. Keep records.
9. Follow up.

In person:

1. Be on time!
2. Use positive body language.
3. Watch your appearance.
4. Maintain eye contact.

There is also help available through http://www.RxHope.com "which can help prescribers obtain these medications for their patients when the patient is unable to afford them and does not have access to prescription insurance or government-funded programs." "If you would like to contact RxHope.com, please complete the form below then submit your request. You may also contact us by telephone at 1(877)979-4673, or through e-mail at customerservice@rxhope.com.

AND through

http://www.phrma.org/searchcures/dpdpap/

The research-based pharmaceutical industry has had a long-standing tradition of providing prescription medicines free of charge to physicians whose patients might not otherwise have access to necessary medicines.

To make it easier for physicians to identify the growing number of programs available for needy patients, member companies of the Pharmaceutical Research and Manufacturers of America (PhRMA) created this directory. It lists company programs that provide drugs to physicians whose patients could not otherwise afford them. The programs are listed alphabetically by company. Under the entry for each program is information about how to make a request for assistance, what prescription medicines are covered, and basic eligibility criteria.

PHARMACEUTICAL COMPANIES

Celexa (antidepressant) 800-851-0758

Depakote (mood stabilizer)/Abbott Pharmaceuticals 800-222-6885 x568

Effexor (antidepressant)/Wyeth Pharmaceuticals 800-568-9938

Neurontin (mood stabilizer)/Parke-Davis Pharmaceuticals 800-725-1247;609-854-5902

Paxil (antidepressant/OCD)/SmithKlineBeecham 800-729-4544

Prozac (antidepressant)/Lilly 800-545-6962

Risperdal (atypical antipsychotic)/Janssen Pharmaceuticals 800-652-6227

Seroquel (atypical antipsychotic)/Zeneca Pharmaceuticals 800-424-3727; 800-456-3669x2231

Serzone/Buspar (antianxiety)/Squibb Pharmaceuticals 800-736-0003

Zoloft (antidepressant)/Pfizer Pharmaceuticals 800-646-4455

Zyprexa (atypical antipsychotic)/Lilly 800-488-2133

Honorable Arlen Specter
530 Hart Senate Office Building
Washington, DC 20510

Honorable Rick Santorum
United States Senate,
Washington, DC 20510

Dear Senator:

I am writing to you because I am concerned about the cost of prescription drugs. People in Pennsylvania are paying more than other people – sometimes twice as much as other people. Some people have to make a choice between taking medicine and caring for other basic needs. This is not right.

I would like you to do what you can to make sure that people in the US pay the same price as people in other countries.

I also want you to include prescription drug coverage in Medicare.

Please write to me with your response.

Thank you,

State Senator Vincent Fumo
1208 Tasker Street
Philadelphia, PA 19148

Dear Senator Fumo:

I am writing to you to ask for help for the elderly who experience depression, anxiety and loneliness. There are many people I know who need help.

I know that there is $1.8 Billion dollars that will be spent for mental health programs but that almost nothing of that is for programs for older adults.

Older adult's needs are for counselors to come to people's homes, for programs that understand aging, and that overcome the stigma of mental illness .

Please support mental health programs for older adults.

Sincerely,

Cultural Competency Toolkit

CHAPTER 7

Outreach to Seniors

The Mental Health Association in Aiken County
149 Chesterfield Street, S.W.
P.O. Box 1074
Aiken, South Carolina 29802-1074
Tel. (803) 641-4164
Fax. (803) 641-4166
E-mail: mhaac@duesouth.net

Constance Shepard, Project Director

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Executive Summary

Aiken County, South Carolina is rated as one of the top 100 places to retire in the United States, but local mental health services to the elderly are not sufficient for this high population of senior citizens. While eleven percent of the people residing in the area are seniors, only four percent of the consumers served by the local mental health service agency are of this age group. The Mental Health Association in Aiken County (MHAAC) proposed to confront this problem by forming a Seniors Task Force made up of local mental health organizations, organizations providing services to older Americans, and mental health consumers and caregivers. This task force would discuss how best to improve mental health services to Aiken County's senior citizens, and would then act upon these recommendations.

Project Goals

- To form a Seniors Task Force of elder-serving agencies, consumers, family members, caregivers and other interested parties.
- To follow the recommendations set by the task force.

Introduction

Aiken County, South Carolina is rated as one of the top 100 places in the United States to retire, and accordingly the region is home to a substantial elderly population. Yet research conducted by the Aiken-Barnwell Mental Health Center (ABMHC), the county's public, outpatient mental health provider, suggests that county mental health services to the elderly are lacking.

Aiken County, South Carolina, rated one of the top 100 places in the United States to retire, is home to a substantial elderly population.

ABMHC offers a traditional range of services including psychiatric evaluations, medication management, case management, crisis intervention, and outpatient therapy and psychosocial rehabilitation, to people of all ages and functional levels. For the most part, this organization does a very competent job of meeting the community's needs and it has received high marks in consumer satisfaction surveys.

As a function of its quality improvement process, ABMHC evaluates its service delivery in light of accessibility, secondary and tertiary consumer satisfaction, and effectiveness and efficiency of services. This evaluation process, which entails a minimum of one major satisfaction survey and one needs assessment conducted annually, involves a review of internal clinical and administrative data; input from consumers, families, agencies, and ABMHC staff; and comparison of ABMHC demographics with county and state demographics.

Outreach to Seniors

In the two years preceding this grant proposal, reviews of ABMHC's services and operations revealed services to the elderly to be an area of concern. While eleven percent of the people residing in ABMHC's catchment area were 65 years old or older, only four percent of the consumers served by the organization were of this age group. ABMHC did not have any programs or services designed specifically for the elderly, nor did it employ a geriatric mental health specialist.

At the time of this grant proposal, Aiken's public mental health provider did not have any programs or services designed specifically for the elderly.

Members of the Aiken Senior Task Force

- Aiken Area Council on Aging
- Aiken-Barnwell Mental Health Center
- Aiken County Coroner's Office
- Aiken Psychiatric Associates
- Aurora Pavilion
- Cornerstone Baptist Church
- Department of Health and Environmental Controls
- Department of Social Services
- Edengardens of Aiken
- Lower Savannah Council of Government
- Mental Health Association of Aiken County
- Parker's Community Center
- Pepperhill Nursing Center
- Shadow Oaks
- Southern Home Care Services
- Vocational Rehab
- We Care

Program Plan

MHAAC proposed to confront the problem of insufficient mental health services for senior citizens in its area by forming a Seniors Task Force made up of local mental health organizations, organizations providing services to older Americans, and mental health consumers and caregivers. This task force would discuss how best to improve mental health services to Aiken County's senior citizens, and would then act upon these recommendations.

Organizational Overview

MHAAC began in 1967 as a volunteer organization dedicated to improving services to people with mental illness, removing the stigma of mental illness, and promoting good mental health. One of twenty affiliates of the National Mental Health Association in South Carolina, MHAAC has been recognized with a number of local awards and honors, including receiving the Outstanding Affiliate Award by the state mental health association five times in ten years.

MHAAC's primary focus is the improvement of quality of life for persons with serious mental illness through advocacy and direct intervention. When deinstitutionalization became South Carolina's policy of dealing with many of the state's severely and persistently mentally ill consumers, this mission took on increased urgency. Assimilation of consumers into the mainstream of the community has become one of MHAAC's primary goals.

Accordingly, MHAAC has developed a number of programs and events to support persons with mental illness residing in Aiken County. These included, "A Place of Our Own" Drop In Center, where consumers can socialize, partake in leisure activities, learn psychosocial and employment skills, and get additional support as needed; Operation Santa, which ensures that adults with mental illness living in the community and adolescents in state hospitals receive gifts and a holiday meal at Christmas; the Consumer Trust Fund to provide consumers with assistance in budgeting, financial management and banking; and onsite leisure and socialization activities provided at local community care homes. In addition, MHAAC provides transportation for consumers in Aiken County, since the public transportation system is almost non-existent.

Implementation

MHAAC's first step in implementing this project was to invite elder-serving agencies in the area to join a senior task force to review mental health needs of Aiken County 's senior population. MHAAC was enormously successful in this endeavor, managing to bring together some 45 representatives of 17 different organizations who then met regularly, twice per month. Senior caregivers from different agencies, including consumers, family members and professionals throughout the Aiken County community gathered to evaluate the mental health and related needs of seniors, to identify barriers to seniors getting their mental health needs met, and to develop a plan to address those needs and barriers.

Senior caregivers from different agencies — including consumers, family members and professionals — gathered to evaluate the mental health needs of area seniors.

The task force decided initially to focus on providing public education on the mental health needs of seniors. In cooperation with the City of Aiken, they planned and organized a half-day "Senior Spectacular," emphasizing mental and physical health during the aging process. Seniors and other interested persons who attended could gather educational materials, visit interactive exhibits, attend speeches, fill out a needs assessment survey (to be used later by the task force), participate in screenings, and enjoy food and prizes.

"Many people think that depression is just a part of growing old. They don't realize that older adults can be successfully treated just like anyone else."

— Constance Shepard, project director

Discussion and Conclusion

Aiken County's Senior Task Force provided a forum where leaders in the mental health community were able to exchange valuable insights and ideas. Mostly, the group concurred that misconceptions about senior citizens' mental health needs abound. Says Constance Shepard, project director, "there is a great deal of public education that still needs to be done concerning older adults and mental health. Many people — including treatment providers — think that depression is just a part of growing old. They don't realize that older adults can be successfully treated just like anyone else."

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Shepard readily acknowledges that getting the task force off the ground was much more difficult than she had anticipated. "It took more time than I expected for the group to gel... In the beginning, everyone was invited to participate, but it took a little while to learn which groups were really serious about participating and contributing." Some advice she offers to others attempting to replicate this project: "It is best to make it clear what it means to collaborate from the beginning." In this way, organizations can honestly evaluate whether they truly have the time and resources needed to participate.

But now that the Aiken County Senior Task Force is a stable, functioning group, its work will continue beyond this grant period. Based upon the results of the needs assessment distributed at the Senior Spectacular, the task force will be setting new goals for improving mental health services to the elderly in Aiken County. In particular, the Aiken-Barnwell Mental Health Center, Aiken Psychiatric Associates, and Aurora Pavilion of Aiken Regional Medical Services intend to take a leadership role in improving mental health service delivery.

The task force will also be turning to the broader question of providing culturally competent services to older Americans of diverse ethnic backgrounds. At the time of this writing, task force members were planning an upcoming "Aging and Mental Health: Facts and Fiction" conference that would include a discussion on cultural competency. Additionally, they were planning to offer a county-wide cultural competency training in the near future.

A King and Queen are crowned at the Senior Spectacular.

Additional Resources

Publications

Fogel, Barry S., Furino, Antonio and Gottlieb, Gary L. *Mental Health Policy for Older Americans: Protecting Minds at Risk.* Washington, D.C.: American Psychiatric Press. 1990.

Gatz, Margaret (editor). *Emerging Issues in Mental Health and Aging.* Washington, D.C.: American Psychological Association. 1995.

Knight, Bob. *Outreach With the Elderly: Community Education, Assessment and Therapy.* New York: New York University Press. 1989.

Smyer, Michael A. and Qualls, Sara H. *Aging and Mental Health (Understanding Aging).* Malden, Massachusetts: Blackwell Publishers. 1998.

Tice, Carolyn J. and Perkins, Kathleen R. *Mental Health Issues and Aging: Building on the Strengths of Older Persons.* Pacific Grove, California: Brooks/Cole. 1996.

Zarit, Steven H. and Zarit, Judy M. *Mental Disorders in Older Adults: Fundamentals of Assessment and Treatment.* New York: Guilford Press. 1998.

Organizations

American Association for Geriatric Psychiatry
7910 Woodmont Avenue, Bethesda, MD 20814-3004
Tel. (301) 654-7850
Fax. (301) 654-4137
E-mail: info@aagponline.org
Website: www.aagpgpa.org

United Seniors Health Cooperative
Suite 200 409 Third Street, S.W., Washington, D.C. 20024
Tel. (202) 479-6973
Fax. (202) 479-6660
E-mail: ushc@unitedseniorshealth.org
Website: www.unitedseniorshealth.org

Internet Resources

Medicare: The Official U.S. Government Site for Medicare Information. www.medicare.gov

Mental Health Association of Southeastern Pennsylvania: Mental Health and Aging. www.mhaging.org

AIKEN COUNTY SENIOR TASK FORCE
and
ABMHC SENIOR PROGRAM

The Aiken County Senior Task Force was created to help meet the needs, primarily from a mental health perspective, of the senior population in Aiken County. Senior caregivers from different agencies, including consumers, family members and professionals, throughout the Aiken County community agreed to participate on a Senior Task Force to evaluate the mental health and related needs of seniors, identify barriers to seniors getting their mental health needs met, and develop a plan to address those needs and barriers. The agencies and programs represented included the Mental Health Association in Aiken County, Aiken-Barnwell Mental Health Center, Aiken County Council on Aging, Aiken Psychiatric Associates, Aurora Pavilion, the Department of Health and Environmental Control, the Department of Social Services, Eden Gardens of Aiken, Hitchcock Home Health Services, Lower Savannah Council of Governments, Pepperhill Nursing Center, Shadow Oaks, and Southern Home Care Services.

The first official meeting of the task force occurred October 19, 2000. The task force has continued to meet on a monthly basis and determined that the primary mental health and related needs of seniors were overcoming the stigma associated with mental health concerns and in-home services for persons who are homebound. The task force has focused on increasing awareness of issues pertaining to the senior population and on education. The task force members decided to concentrate on a major event which will demonstrate appreciation of seniors and will provide education for seniors on services and programs that are available to them.

On May 4, 2001, the task force, in coordination with the City of Aiken, will present Senior Spectacular, a four-hour event open to the public that will offer education materials, interactive exhibits, speakers, needs assessments and food for the senior population and all interested persons. The emphasis will be on mental and physical health during the aging process. ABMHC will support a booth with educational material about depression, Alzheimer's Disease, end of life issues, caregiving and the center itself. Grant monies will be used to purchase the educational materials.

With the approach of Senior Spectacular the task force is looking to set new goals which will be finalized with the results from the needs assessments distributed at Senior Spectacular. The primary focus of the new goals will be the provision of mental health services. This effort will be led by Aiken-Barnwell Mental Health Center (ABMHC), a community mental health center offering a full range of outpatient mental health services; Aiken Psychiatric Associates, an outpatient psychiatric service led by a psychiatrist specializing in the treatment of seniors; and Aurora Pavilion, the mental health program of the Aiken Regional Medical Services, which provides inpatient and outpatient services to seniors.

The Senior Task Force participants believe there is a senior population within Aiken County whose needs are not being addressed. The population is the group of seniors who do not qualify for Medicaid nor have the financial resources to meet their own physical and/or mental needs. Seniors with dementia, depression and/or physical complications that render them housebound are often relying on family caretakers who often must forsake their own source of income to help the senior family member. The result can be extreme emotional distress for both the senior and the caretaker. Transportation to community services is sometimes limited due to finances and/or physical limitation, thus severing this group of people from health services. Medicare has few allowances to meet this population's needs,

especially from a mental health perspective. Medicare also does not provide for transportation costs to assist these people.

ABMHC's current services to seniors are included in its general Adult Outpatient Program. While these services meet the needs of consumers who can access facility-based programs, it does not adequately address those people who are homebound. The senior population is under-represented in service delivery, with only 4% of the Center's consumers being sixty years or older, while this population makes up 11% of the community's overall population. The Center is currently developing a program specifically designed for the senior population. This program will ensure the proper diagnoses of mental disorders, implementation of best-practice psychotherapy treatment for the senior population, and coordination with other resources in the community, including.

The ABMHC Senior Program will offer individual, group and family therapy services, crisis services, psychiatric and medication services, and education and support group for caregivers. Key components of the program will be the provision of transportation and of in-home services, and the coordination of services with other providers. The Center will bring seniors into the facility for services, and provide professionals to go into the community to offer services within the home environment for persons unable to be transported for physical or emotional reasons. It should be noted that persons suffering with dementia often have a negative reaction to change in routine, including the introduction of new environments. Therefore, it may not be in the best interests of these persons to be seen at ABMHC, but instead in their home environments. The ABMHC Senior Program will coordinate with home health agencies to ensure the provision of in-home services in a manner that is most likely to be well received by seniors in need of these services.

The Center will prepare a detailed plan for senior mental health care and develop a proposal for South Carolina Department of Mental Health federal block grant funds in order to expand its existing on-site services to homebound seniors in the community. We will also evaluate the possibility of an Adult Day Health Program and continue the Center's contract for respite services for persons with Alzheimer's Disease with the Aiken Council on Aging's Life Connections program. Services and programs will be planned and delivered in consultation with the Senior Task Force. The overriding goals of ABMHC's Senior Program will be to ensure the provision of all mental health services needed by seniors, and to achieve parity of service delivery with other populations served by the mental health center.

Respectfully submitted,

Cynthia Foster

Cynthia Foster, Program Coordinator
Adult Outpatient Services
March 16, 2001

SENIOR SPECTACULAR

MAY 4, 2001
10:00 A.M.-2:00 P.M.

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Cultural Competency Toolkit

CHAPTER 8

Project Intercultural Connection: Meeting Asian Americans' Mental Health Needs

The Asian American Family Counseling Center
6220 Westpark, Suite 104
Houston, Texas 77057
Tel. (713) 339-3688
Fax. (713) 339-3699
E-mail: info@aafcc.org
Website: www.aafcc.org

Deborah Sorensen, Project Co-director
Kim Szeto, Project Co-director

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Executive Summary

Despite the pervasive stereotype that Asian Americans are relatively well-adjusted individuals who encounter few psychological difficulties, mental illnesses among Asian Americans are actually common and this group has a rate of psychopathology, including depression and psychotic disorders, equal to or higher than European Americans. Yet in the Houston area, there are few mental health providers educated in working with this community and there are only a handful of Asian American clinicians. Through Project Intercultural Connection, the Asian American Family Counseling Center (AAFCC) proposed implementing and developing a cultural competency training curriculum for mental health professionals coming into contact with the Asian American population in the greater Houston area.

Project Goals

- To assess the cultural competency needs of area service providers.
- To develop a cultural competency training curriculum for area service providers.
- To provide cultural competency training to area service providers.

Introduction

There seems to be a pervasive view that Asian Americans are relatively well-adjusted individuals who encounter few psychological difficulties. Stereotypic notions still prevail that family systems and strong community ties insulate Asian Americans from psychological concerns.

Stereotypic notions still prevail that family systems and strong community ties insulate Asian Americans from psychological concerns.

The reality, however, is that mental illness among Asian Americans is common and Asian Americans have a rate of psychopathology, including depression and psychotic disorders, equal to or higher than European Americans. Unfortunately, though, very few Asian Americans become mental health practitioners since psychology and counseling are indigenous to Western culture and are unfamiliar disciplines warranting little respect and attention in Asian cultures at this time.

In Houston, specifically, only a handful of Asian American individuals are licensed to practice mental health and most of these individuals are of Chinese and Asian Indian descent. Additionally, AAFCC has discovered, through research undertaken to develop its Asian American resource directory, that most mental health agencies in Houston do not feel that they are familiar enough with Asian cultures to provide culturally competent services.

This makes it very difficult for Asian Americans, particularly non-Chinese Asian Americans, to access culturally and linguistically competent mental health services in Houston.

Even more disturbing is the lack of culturally competent service providers in agencies offering services for clients who cannot afford to pay. The results are poor quality care for indigent and low-income Asian Americans, such as Southeast Asian refugees, who are often forced to accept culturally incompetent services.

For Asian Americans who obtain services from Western mental health practitioners, such as counselors, social workers, or psychologists, Western therapeutic treatment goals and strategies may be both inappropriate and unsuccessful if not reevaluated and tailored to the individual's specific cultural background. Western therapeutic approaches, for example, tend to be oriented towards the importance of the individual. This approach is in direct contrast with traditional Asian cultural views which place the good of the family before that of the individual.

Traditional resources have not been successful in meeting the mental health needs posed by the Asian American community in Houston.

The largest non-Asian provider of services responding to the Asian American needs in the public sector in Houston is the Mental Health and Mental Retardation Authority of Harris County (MHMRA). Their records indicate that a total of 385 Asian Americans were served in fiscal year 1995. This represents 1.2 percent of MHMRA's total clientele and less that three-tenths of one percent of the Asian community in Houston. Clearly, traditional resources have not been successful in meeting the mental health needs posed by the Asian American community in Houston.

Moreover, the Asian American population in the Houston area has continued to grow in recent years. The 1990 census indicated that Asian Americans made up four percent of Houston's population with a growth rate of 96 percent. Recent estimates from the Asian Chamber of Commerce (1995) count 352,000 Asian Americans residing in the Houston area, including 125,000 Vietnamese, 120,000 Chinese, 45,000 Asian Indians, 20,000 Pakistanis, 20,000 Koreans, 14,500 Filipinos and 7,500 Japanese.

Program Plan

To assist local mental health providers in offering more culturally competent services to Houston's Asian Americans, AAFCC proposed Project Intercultural Connection, an ambitious plan to assess local providers' cultural competency needs, to develop a curriculum based upon these needs, and to conduct cultural competency trainings.

Organizational Overview

In 1994, a group of Asian American professionals, including many in the mental health field, came together to voice their concerns about the mental health of the Asian American community in Houston, Texas. These individuals discussed strategies to address the unmet mental healthcare needs of Asian Americans in Houston. These discussions led to the creation of AAFCC, which was formally chartered in May of that year.

AAFCC's overall mission is to enhance the mental health of the Asian American community in greater Houston by: educating the Asian American public and professionals regarding Asian American psychological, social and multi-cultural issues; increasing the competency of mental health professionals in addressing Asian American psychological, social and multi-cultural issues; advocating for mental health resources for the Asian American community; and providing early intervention and mental health treatment through integrated Eastern and Western approaches.

AAFCC staff and board members have conducted training sessions on Asian American mental health issues at such organizations as Houston Area Community Services, the Alliance for Multicultural Services, Houston Area Women's Center, the Alzheimer's Association, the University of Texas Medical Branch Psychiatry Department, the Chinese Community Center, M.D. Anderson Hospital's Department of Social Work, and Fort Bend County Women's Center, among others. AAFCC also produces a quarterly educational newsletter which is disseminated to over 500 individuals and agencies in the Houston area who are interested in cross-cultural mental health issues.

AAFCC staff and volunteers are able to assist clients in ten languages including Mandarin, Cantonese, Vietnamese, Taiwanese, Japanese, Korean, Hindi and Urdu.

A cultural competency survey can assess a practitioner's understanding of . . .

- differences in symptom expression
- differences in communication styles
- mental health terms that do not translate well
- religious beliefs about mental illness
- differences in what is considered "normal" behavior
- differences in help-seeking behavior
- effective, culturally specific counseling skills
- various subcultures within ethnic groups

At the time of this proposal, AAFCC was staffed by an experienced administrator, two licensed clinicians, a cultural diversity educator, and a multi-lingual case manager. In addition to these positions, AAFCC also offered student internships for graduate students in the mental health field, and recruited a number of volunteers from a variety of ethnic backgrounds to assist staff and interns in various capacities. Through a combined effort, AAFCC staff and volunteers were able to assist clients in a total of ten languages including Mandarin, Cantonese, Vietnamese, Taiwanese, Japanese, Korean, Hindi and Urdu.

Implementation

At the outset of this project, Project Intercultural Connection developed a concise, four-page questionnaire to assess service providers' cultural competency based upon the Cultural Competency Standards in Managed Care (2000) and the Multicultural Counseling Awareness Scale (MCAS) developed by Ponteretto, et al (1996). (See Appendix A.)

The survey was sent out to various agencies and organizations in the Houston area that provided counseling and assessment services to clients from different cultural backgrounds, including, among others, the Houston Independent School District's Psychology Department and the Houston Area Women's Center.

Houston practitioners seem to be more knowledgeable about African American and Hispanic minorities than about Asian Americans.

Based upon this survey, Project International Connection gathered some interesting information about clinicians in the Houston area's understanding of diversity issues. Deborah Sorensen, project co-director, comments that "people seemed more knowledgeable" about cultural competency than AAFCC expected. At the same time, she attributes this knowledge to some extent to a built-in bias in the survey. "The people who responded to the survey were most likely those who are interested in cultural issues," she explains.

Yet even those individuals most aware of cultural differences seemed to be more knowledgeable about Houston's African American and Hispanic minorities than about the area's Asian American minorities. And in particular, survey respondents exhibited "little knowledge about 'between group' differences. They were not aware that there are many different cultural groups within the Asian American community," says Sorensen.

AAFCC's Brown Bag Lunch Series

- Intergenerational Conflicts in Asian Families
- Stress and Stress Management in Asian Families
- Cultural Factors Contributing to Psychopathology in Asian Americans
- The Interaction between Cultural Adaptation and Identity Formation
- The Impact of Culture on the Manifestation of Individual Psychopathology

Survey results helped AAFCC to determine what materials should be covered by their cultural competency trainings. In addition, Sorensen and project co-director, Kim Szeto, also considered some of the typical issues that they encountered among the center's client population. The problem that presented itself most was the question of intergenerational conflict, hence the subject of the first brown bag lunch.

From March, 2000 through January, 2001 Project Intercultural Connection sponsored a series of brown bag luncheons providing information on Asian American mental health issues to professionals. Local Asian American clinicians designed and presented these talks.

To recruit participants, Sorensen and Szeto sent invitations to various mental health and community organizations including the Houston Independent School District's Psychology Department, the Chinese Community Center, the MHA of Greater Houston, and the University of Houston's counseling center. They also combed through local directories and attempted exhaustively to contact counselors in the Houston area.

Houston practitioners attend the first brown bag luncheon.

Attendance at the luncheons varied, with the smallest group including 14 people and the largest group including 25. At the end of each brown bag, participants were given evaluation forms to fill out, and the brown bags consistently received high marks.

Discussion

America's Asian American population is actually comprised of a vast array of different nationalities and cultures. In the Houston area alone, AAFCC reports the presence of over twenty different Asian ethnicities—each with its own history, language and customs. Therefore, any project that attempts to reach out to Asian Americans must carefully research exactly who the target audience is. And consumer supporter organizations wishing to serve this heterogeneous body of Asian Americans must be prepared to offer services in an array of languages—or at least to have some cultural understanding of the various groups involved.

There are many different Asian ethnicities—each with its own history, language and customs. Project managers must know who their target audience is.

Another factor to consider when developing programs for Asian Americans is the amount of time a particular group has spent in the United States. Sorensen reports that "most of our Asian population here in Houston are immigrants." This, she says, is in contrast to Asian Americans on the West Coast, most of whom have been living in the United States for several generations. With immigrant populations, where the younger generation is growing up American while the older generation has immigrated from another country and is now adapting to a new American culture, intergenerational conflict may be particularly prevalent.

With immigrant populations, intergenerational conflict may be particularly prevalent.

Conclusion

AFCC will continue to offer Project Intercultural Connection in the years to come, and Sorensen even plans to expand upon the program. For example, she says that "we have had requests to offer longer sessions—people feel that an hour just isn't enough." In the future, consequently, the project might offer longer, evening trainings.

Sorensen also wishes to expand her current pool of trainers and to draw upon all available Asian American practitioners in the Houston area. She acknowledges that "there are not many clinicians to choose from in Houston, and I am constantly on the look-out for new people." Recently, she recruited a researcher who is completing an internship in Houston. His area of specialty is trauma and Post Traumatic Stress Disorder.

Sorensen encourages consumer supporter organizations wishing to launch programs such as Project Intercultural Connection to "be flexible." It is important to learn to answer to the educational needs of the provider community while drawing upon the talents and specialties of the existing pool of trainers.

Additional Resources

Publications

Takaki, Ronald. *Strangers from a Different Shore: A History of Asian Americans*. Boston: Little, Brown. 1998.

Tuan, Mia. *Forever Foreigners or Honorary Whites?: The Asian Ethnic Experience Today*. New Brunswick, New Jersey: Rutgers University Press. 1998.

Uba, Laura. *Asian Americans: Personality Patterns, Identity, and Mental Health*. New York: Guilford Press. 1994.

Zia, Helen. *Asian American Dreams: The Emergence of an American People*. New York: Farrar, Straus, and Giroux. 2000.

Organization

Office of Minority Health
Department of Health and Human Resources
Tel. (800) 444-6472
E-mail: info@omhrc.gov
Website: www.omhrc.gov

Cultural Competency Survey for Mental Health Professionals

developed by the Asian American Family Counseling Center (AAFCC)
for Project Intercultural Connection (PIC)
funded by the National Mental Health Association (NMHA)

Please return to: AAFCC, 6220 Westpark, Suite 104, Houston, TX, 77057 by Friday, July 7, 2000. You may also access this survey through the AAFCC website (www.AAFCC.org) and return it via e-mail (Info@AAFCC.org).

Section I -- Demographic Information

Please circle or fill in the blank with the correct information.

1. **Place of Employment**: (optional):
_____

2. **Age** (optional): _____

3. **Gender** (optional): Male
Female

4. **Ethnicity** (optional):_____

5. **Level of Education**: High School diploma
Bachelor's degree
Master's degree
Ph.D.
M.D.
Other: _____

6. **Type of License**: LPC
LMFT
LMSW
LMSW-ACP
Licensed Psychologist
Other: _____

7. **Type of Practice**:
Setting: _____
Specialization: _____

8. **Years in Practice**: _____

Section II – "Food for Thought"

The following questions are intended to help you as a mental health practitioner to assess the strengths and weaknesses of your cross-cultural counseling skills as well as your training needs. This survey should not be used as a test of cultural competency skills. Instead, these questions should stimulate thought about cross-cultural interactions in mental health settings so that you will be able to evaluate your cross-cultural awareness, knowledge, and skills in the final section of this survey. If you need more space, please attach a blank page on which to complete your answers.

1. How familiar are you with cultural differences in symptom expression (E.g., dysphoria is often highly somaticized in Asian cultures), symptom language (E.g., among Asians and Hispanics, both illnesses and treatments may be referred to in terms of hot/cold or humoral theory), and symptomatic patterns of mental illness/ emotional disturbance among various cultural groups (E.g., PTSD is extremely common among refugee groups)?

2. How much do you know about culture-bound syndromes? (E.g., susto, koro, zar, taijin kyofusho, etc.)

3. How familiar are you of differences in nonverbal language, speech patterns, and communication styles among different cultural groups? (E.g., Native Americans may avoid eye contact. When communicating with others, Hispanics may prefer to stand close and may seem to invade your personal space. Asians may not wish to express anything that will create conflict.)

4. a) Are you aware that certain words, phrases, and expressions may not translate well from one language to another? (E.g., The English term "counseling" is difficult to translate into Chinese. Also, although the term "susto" in Spanish is translated into English as "shock," the condition of "susto" cannot be translated this simply and refers to much more than shock.)
   b) How well are you able to keep this in mind when working with a client through an interpreter or when working with a client whose primary language is not English?

5. a) Are you aware that some cultures attribute mental illness to religious (E.g., "divine punishment") and/or supernatural (E.g., "evil eye," curses, witchcraft) causes?
   b) Are you tolerant of these beliefs?
   c) How would you react to a client or client's family who expressed such ideas?

6. a) Are you aware that culturally acceptable behavior or what's considered normal varies among cultural groups?
   b) Are you familiar with some of these variations? (E.g., Among many Hispanics and Asians, personal autonomy is not the norm. Instead families often make decisions for individuals. Also, while the nuclear family is the ideal family structure for most European Americans, extended family households are not uncommon among Asians and Hispanics and kinship care is not uncommon among African Americans.)
   c) How comfortable are you when confronted with such differences in a therapeutic relationship?

7. Are you aware of differences in help-seeking behaviors among ethnic/cultural groups? (E.g., Among Asians, mental or emotional problems are often highly stigmatized. Many Asians, therefore, wait until a problem has become severe and seek outside help only as a last resort. Also, both Hispanics and Asians may discontinue treatment once a crisis is over).

8. How familiar are you with different religious/spiritual beliefs and indigenous healing practices among various cultural groups? (E.g., African Americans may seek help for mental health related problems through their church. Hispanics may seek the help of curanderos or indigenous healers, while Asians may seek help from herbal medicine or acupuncturists).

9. a) Are you aware of certain counseling skills, techniques, or approaches that are more likely to transcend culture and be effective with your clients?
   b) Are you aware of treatment modalities which are appropriate and effective for particular cultural groups?
   c) Are you aware of some culturally indigenous models of counseling for various ethnic groups?
   d) How comfortable are you using these various techniques (referred to in questions a, b, and c)?

10. a) Are you able to identify and take into consideration when doing therapy that certain values and patterns of behavior in your own culture may not be common in other cultures?
    b) How likely are you to assume that your own cultural values will be held by your clients and intentionally (or unintentionally) impose these values on your clients? (E.g., As an American, you may be extremely independent and individualistic, but Asians and Hispanics may be oriented more towards interdependence with family and community members. However, in contrast, Western developed therapeutic approaches often implicitly stress the welfare of the individual.)

11. How well do you think you understand the role of culture and ethnicity in the development of identity and world view among various cultural and ethnic groups? (E.g., Identity formation may be more difficult for adolescents struggling to fit into the world of their native culture as well as the American mainstream. Factors such as racism and discrimination may affect the way individuals perceive the world.)

12. How aware are you of the differences among subcultures of the larger ethnic groups? (E.g., Among Hispanics in Houston, there are major cultural differences among Mexicans and Salvadorans. There are also cultural and linguistic differences among the many Asian ethnic groups such as Vietnamese, Chinese, Indian, etc.)

13. a) Do you allow for individual differences among members of a particular cultural or ethnic group?
    b) How aware are you of social/environmental factors which can influence individual differences among cultural groups in the U.S. (E.g., level of acculturation, age, gender, length of time in U.S., religion, family structure, socioeconomic status, education, employment status, etc.)

14. a) Do you strive to improve your cross-cultural counseling skills regularly?
    b) How do you do this? (E.g., Do you read the work of cross-cultural mental health researchers and writers such as Donald Atkinson, J. Manuel Casas, Janet Helms, Arthur Kleinman, Teresa LaFromboise, Paul Pedersen, Derald Wing Sue, or others? Do you attend cross-cultural continuing education workshops or training sessions? How often do you consult with cultural specialists? Do you follow cross-cultural mental health research through mental health journals?, etc.)

15. a) Do you think that you are able to form effective working relationships with clients from different cultural backgrounds?
    b) Why or why not?

Section III – Evaluate Your Cross-Cultural Awareness, Knowledge, and Skills

Based upon what you have learned by contemplating and responding to the 15 questions above, please critically evaluate your cross-cultural awareness, knowledge, and skills by answering the following questions.

1. What are your cross-cultural counseling strengths?

2. What are your cross-cultural counseling weaknesses and limitations?

3. What are your cross-cultural training needs? What do you need help with?

4. ***Awareness*** of cultural differences is the first step in becoming a culturally competent mental health practitioner. ***Knowledge*** of these differences is the second step. Acquiring the ***skills*** to work with clients from different cultural backgrounds is the final step. Where do you think you are in this process and where do you need the most help?

This survey was developed by the Asian American Family Counseling Center based upon Cultural Competence Standards in Managed Care (2000) and the Multicultural Counseling Awareness Scale (MCAS) developed by Ponteretto, et al. (1996).

Thank you for your participation!

Examining the Need for Cultural Competency Training among Mental Health Professionals

by Deborah Gober Sorensen

An awareness of the growing diversity of Houston's population has led many mental health professionals in the greater Houston area to converge on cultural sensitivity workshops or diversity training sessions for direction and guidance. However, cross-cultural "competence" cannot be achieved by attending one or two training sessions. Instead, learning about cultural differences can perhaps best be thought of as a process. Whereas it may be impossible for mental health professionals to learn everything there is to know about all of the diverse cultures represented in Houston today, it is possible to learn about cultural variability as well as the relativity of one's own culture, values, and experiences. For mental health care professionals, in particular, though, sensitivity alone may not be enough to ensure the successful treatment of a client from a different cultural background. The mental health practitioner must be able to understand the viewpoint of his/her client's culture and apply this understanding to his/her treatment strategy to be effective. Therefore, cross-cultural training for mental health professionals should also address issues such as attaining cross-cultural treatment skills and strategies.

The necessity of implementing a cultural competency training program for mental health practitioners serving Asian American clients in the Houston area has become glaringly apparent as the Asian American population continues to grow in Houston. The 1990 Census indicated that Asian Americans make up 4% of Houston's population with a growth rate of 96%. By the end of 2000, the Asian American population in Houston is predicted to double once again. Houston's Asian American population includes more than twenty different Asian ethnicities with their own cultures, languages, and customs. Although it is often assumed that all Asian Americans are well-adjusted, successful individuals, in fact, contrary to the prevailing stereotype, mental illness among Asian Americans is actually quite common. Moreover, Asian Americans have a rate of psychopathology, including depression and psychotic disorders, equal to or higher than that of European Americans. Despite these facts, culturally competent mental health resources for Asian Americans remain limited. When Asian Americans are ready to seek help, they are often confronted with the unavailability of service providers who can accommodate their respective languages and cultures. Western therapeutic treatment goals and strategies may be both inappropriate and unsuccessful if not reevaluated and tailored to the individual's specific cultural background. For example, Western therapeutic approaches tend to be oriented towards the importance of the individual. This is in direct contrast with traditional Asian cultural views, which place the good of the family before the individual.

Treating Asian American clients is even further complicated by the extreme diversity of the Asian American population in Houston today. Each Asian ethnic group possesses unique cultural values and beliefs that may impact the therapeutic process and therefore, must be addressed. Additionally, differences among Asian Americans can also be the direct result of migrational or generational factors. For example, refugees may have experienced traumatic events before emigration leading to post-traumatic stress disorder. Asians who have been born and raised in the United States also face their own unique set of problems such as identity issues, intergenerational conflicts, and bicultural conflicts. Therefore, in addition to an understanding of the specific culture of the client, it is also important for the practitioner to be sensitive to a variety of other factors if they are to effectively and successfully treat Asian American clients.

Culturally and linguistically competent mental health services for Asian Americans are difficult to find in Houston for a number of reasons. First of all, unfortunately, very few Asian Americans enter into mental health fields since psychology and counseling are indigenous to Western culture and are unfamiliar disciplines warranting little respect and attention in Asian cultures at this time. In Houston, specifically, only a handful of Asian American individuals are licensed mental health professionals, and most of these individuals are of Chinese or Indian descent. Additionally, AAFCC has discovered, through research undertaken to develop our Asian American resource directory that most mental health agencies in Houston do not feel that they are familiar enough with Asian cultures to provide culturally competent services.

It is precisely this lack of culturally competent mental health resources for Asian Americans in the Houston area that has led to the growth and development of AAFCC. In an effort to increase the cultural knowledge of mental health resources available to Asian Americans, AAFCC provides educational presentations about Asian cultures to mental health and social service agencies in the Houston area. AAFCC also offers internship opportunities for students in the mental health fields so that future mental health professionals will learn more about working with Asian clients. AAFCC's latest effort to increase cultural competency among mental health professionals in Houston, Project Intercultural Connection (PIC), is funded by the National Mental Health Association. The ultimate goal of PIC is to improve the intercultural knowledge base and skills of mental health professionals in the Houston area. For more information about participating in PIC's cultural competency training program, please contact the AAFCC office.

*For more information, please contact the **Asian American Family Counseling Center** at 6220 Westpark, Suite #104, Houston, TX 77057, telephone #713-339-3688, fax #713-339-3699, or e-mail info@aafcc.org.

Additional Resources

1) Exploring Aspects of Filipino-American Families
Journal of Marital and Family Therapy 1996 vol 22, No.2, 205-217.

2) Cultural patterns and the Family System in Asian Indians: Implications for Psychotherapy
Journal of Comparative Family Studies Vol. XX, Number 3 (Autumn 1989)

3) A Manifesto of an Indo-American Youth
http://indiastar.com/anony.html

4) Intergenerational Relationships in Iu Mien Families
by Chua Chime Chao
http://www.aad.berkeley.edu/uga/osl/mcnair/93BerkeleyMcnairJournal/chuaChao.html

5) My Father's Shadow
Reader's Digest, March 2000, p 23

6) **The Joy Luck Club**
by Amy Tan

7) **Special Care Series:** Book 1 Establishing Significance
Book 2 Understanding Grief
Book 3 the Gift of Understanding
Book 4 Reconstructing Our lives
by Doug Manning

8) **Journal of Cross Cultural Psychology**
Sage Publications

9) **The Mental Health of Asian Americans**
by Stanley Sue

10) **Counseling the Culturally Different**
by Derald Wing Sue

11) **Ethnicity & Family Therapy**
edited by Monica McGoldrick, J. Giodano & J.K. Pearce

12) **Children of Color**
edited by J. Taylor Gibbs and L. N. Huang

13) **National Asian Women's Health Organization**
Phone 415-989-9747, Fax 415-989-9758, www.naswho.org

14) **Mental Health Issues for Minority Seniors,** published by AARP

15) **Closing the Gap,** published by the U.S. Department of Health and Human Services, Office of Minority Health

16) **Mental Health Services for Refugees,** published by the U.S. Department of Health and Human Services, Alcohol, Drug Abuse and Mental Health Administration

17) **DAYA,** non-profit organization helping South Asian victims of domestic violence
Phone 713-914-1333

Intergenerational Conflicts in Asian American Families

Outline for Discussion:

I. Conflict
- What is it?

II. Conflicts between generations
- What's common throughout history?

III. Conflicts in Asian Americans
- Is it Asian?
- Is it culture?
- Or is it rate of acculturation?
- Are there differences between first and second, second and third, third and fourth generation immigrants?

IV. Culturally prescribed ways of dealing with conflicts
- What were the old ways?

V. Culturally acceptable ways to express anger
- Can they find a middle ground?

VI. Culturally defined "norms"
- What's acceptable?
- What's not acceptable?

VII. Power structure in immigrant families
- Is restoring parental authority always possible?

VIII. "Learn to accept what cannot be changed, have the courage to change what you can, and have the wisdom to know the difference."

THE FIVE STAGES OF GRIEF OR ACCULTURATION

1. DENIAL/NUMBNESS
   - Survival mode
   - Meeting basic needs
   - Withdrawal from mainstream
   - Ethnocentrism

2. ANGER
   - Entitlement
   - Blaming
   - Retaliation
   - Discriminate against other minorities and mainstream
   - Self-hatred- Completely reverse values and adopt the mainstream values

3. DEPRESSION
   - Helplessness
   - Give up
   - Wanting to return home

4. BARGAINING
   - Mediating needs
   - Compromising values
   - Trying to adapt

5. ACCEPTANCE
   - Seeing the light at the end of the tunnel
   - Benefiting from both cultures
   - Forming a new identity -- Asian American.

Questions to ask your
Asian American & Pacific Islander (AAPI) Immigrant Clients

START with where the client is:

1) Immigrant or Refugee?
   -Circumstances under which the immigration took place (ie: war)

2) How long have they been in the U.S.?
   -First generation in the U.S.?
   -Age of first entry to U.S.?
   -Where have they lived (before and after immigration)?
   -Why Houston and why now?

3) Language ability?

4) Legal status?
   -Citizen?
   -Permanent resident?
   -Work history (Medicare and SS/DI eligible)?
   -Meet residency requirement?

5) Prior skill level before immigration?
   -What skills have they developed after immigration?
   -Education level?

6) How have they coped with losses?
   -Family intact?

7) Cultural/Ethnic identity?
   -How do they see themselves?

8) How did their growing up experience affect them?
   -Ask them to name three things that have influenced them the most.

Common Problem Areas for AAPI Immigrants:

- Survival issues: limited job opportunities due to language deficits
- Lowered social status
- Lack of health insurance
- Lack of access to all services due to language/cultural barriers
- Mental health issues -paucity of culturally competent clinician
- Poor social/community support -no infra structure
- Long term care
- Institutional barriers-Gate keepers who keep them **OUT**-see only rigid eligibility rules, overlooking the person
- Need to defend Values nobody understands: especially to their own children

by Melody M. Lin, LMSW-ACP

Working with Asian American Clients

1) How do you find out who they are?

2) Dealing with transference (Asian clients are so much trouble) and counter- transference issues (how do they see you?)

3) How to overcome the language gap?

4) How to select the appropriate theoretical framework?

5) Is spirituality/religion an issue?

6) Treatment strategies
   - What does the research say?
   - What are your experiences?

7) Where do you get help?
   - Who's your cultural broker?
   - Who do you call for consultation?

8) Collaboration?

Stress and Stress Management in Asians
Outline & Notes for Brown Bag #2

I. What is stress?
   A. All human beings encounter stress.
   B. Stress can result in increased adaptive strength or deterioration (physical and/or psychological).
   C. The accumulation of many life changes over a short period of time is related to well-being. The more the changes, the greater they are, and the shorter the period of time in which they occur, the greater the chance that physical and psychological health will be affected. This is particularly true if the life changes are undesirable (losing a job, divorce) as compared to desirable (marriage).
   D. Too many intense life changes over a short period of time create stress and make it difficult for individuals to adapt quickly enough to catch up.
   E. Major life events demand a great deal of social readjustment and adaptation.

II. Sources of Stress in Various Asian Populations
   A. Immigrants
      1) Acculturative Stress
         a) Acculturation is the process of adapting to and adopting a new culture.
         b) Acculturative stress is the conflict that arises in individuals when they strive to resolve or minimize cultural differences between themselves and their host culture.
         c) When acculturative stress becomes severe, it can become a threat to the psychological well-being of immigrants and may result in a number of psychological symptoms, particularly depression.
         d) Acculturative stress is greatest when the two cultures are extremely dissimilar and also when the pressure to conform is great.
         e) The acculturation process for immigrants usually involves such things as learning a new language, redefining roles, rebuilding social networks, finding emplyment, acquiring housing, adjusting to a new climate, as well as integrating the values and norms of the host society.
   B. Second Generation and Up
      1) Cultural Conflicts
      2) Racism, prejudice, facing stereotypes
      3) Meeting the high standards of the Asian community.
         Many things that are considered acceptable among Americans may be considered unacceptable and even shameful among some Asian Americans. For example, divorce, getting fired from a job, being arrested or facing legal trouble, doing poorly in school (or having a

child do poorly in school). All of these things would most likely be stressful for any American, but among Asian Americans, because of the shame often associated with these events, the degree of stress experienced may actually be much greater. There may be a need to hide any of these things. Therefore, they may have no one to talk to and no support.

C. Children and Adolescents
   1) Cultural Conflicts
   2) School Pressure – extreme importance and emphasis is placed on academic achievement and success in Asian cultures. Test Anxiety – a significant stressor in many Asian countries such as India, Japan, Hong Kong, Singapore). Many immigrant children may still suffer from this problem.

D. Families
   1) Intergenerational Conflicts
   2) Role Adjustments

E. Women

Often must function in a dual role as traditional wife and mother, but also often must bring in income as well. Both roles are highly demanding and result in stress. Also, the conflict between these roles may create stress.

F. Men

May experience a loss in authority as their wives begin to work and their children act as mediators to the outside world.

G. Elderly

-May experience a loss of respect. May feel that they are not treated as well as they would be in their homeland. Their children and grandchildren may have very busy schedules, so they may feel left out, neglected, unwanted. This may result in depression or even suicide. They also may resent and become angry at their children for not taking care of them they way they think they deserve. This may result in passive-aggressive behavior.

-In turn, their children may feel obligated to care for them, but may feel stress trying to care for them, their families, and work as well. They may feel stressed and overwhelmed. But, they may also feel guilt (not being a good enough son/daughter and not taking care of their parent well enough) and resentment (why do I always have to be the one to take care of him/her? Americans don't have to go through this with their parents.)

III. Buffers to Stress among Asian Americans

A. Locus of Control
   1) Internal – the individual feels in control of his/her own life. Common among Westerners. Associated with lower stress.
   2) External – the individual believes that outside forces control your life. Common among many Asians. This was once associated with higher levels of stress, but for Asians, this may not necessarily be the case. Some studies have found that for Asians who believe that God or fate controls their lives, this relieves them

of the personal responsibility for what is happening to them. Thereby, reducing stress.

B. Personality Factors
   1) The ability to be flexible and accept alternatives protects against stress.
   2) On the other hand, individuals who are perfectionists and highly structured (inflexible) often experience more stress.

C. Social Support
   1) Joint or Extended Family System
      Common pattern for Asian families. May provide a large supportive social network, but the extended family is often torn apart during immigration. This can then lead to more stress as individual family members are left feeling isolated and don't know where to turn.
   2) Other sources of support include friends, neighbors, community ties. During stress, Asian individuals first turn to their family for support, then may often turn to respected third parties or intermediaries in the community (eg., respected elders, community leaders, teachers, ministers, physicians). As a last resort, they may turn to Western mental health professionals.
   3) Women tend to have more social support than men, particularly when many Asian males feel extreme pressure to appear strong and may hide the need for help or support.

D. Philosophy in which suffering is valued
   Many Buddhists and Hindus believe that it is useless to challenge fate. Therefore, one must learn to persevere and endure. Suffering without complaint is therefore considered to be an honorable way of dealing with adverse situations and puts one on the road to transcendence. This philosophy may actually help many Asians to accept and deal with the adverse circumstances which they encounter including such things as poverty and personal loss. This philosophy may, therefore, help to buffer against stress.

E. Strong bicultural identity and good bicultural skills
   If an individual can adapt and act appropriately according to the situation dictated by the culture, the effects of cultural conflict can be minimized.

IV. How to approach stress in therapy
   Thach

V. Indigenous Relaxation Methods
   - Meditation
   - Yoga
   - Tai-chi
   - Qi Gong
   - Writing Chinese calligraphy (has been found to have calming effects)

Cultural Factors that Contribute to Psychopathology

The myths of the model minority
-From the outward looking in, we strikingly appear to be a relatively well-adapted racial/ethnic group: Hard working, closed-knit, family ties, academically successful, business-venturesome, law-abiding citizens, community unity, low rate of mental illness " wherever the Asians grow roots, prosperity follows"

The family unity myth:
Family can create a buffer or a bondage to mental health.

Family is an economic system with build-in social security for the parents.

1. Child-rearing style—Children as an extension of parents, not individual beings.
   -Prolong childhood and adolescence- to keep the children under control and deepen and strengthen the bonding with the parents:
   -Children being spoon-fed and bathed until 5-6 or throughout grade school
   -Due to multiple children and economic hardship, children have no diapers and have total freedom to unrestricted toilet training technique, do what you want-anal personality: extremely frugal or exceedingly extravaganza
   -Harsh weaning method and lack of father figure create orally fixated and addictive personality traits—70% adults gamble, 90% drinks, smoke before the age of 18.
   -Children sleep with parents all through elementary—Deepen bonding, quality time, but can be too much of a good thing, sexual trauma.
   -Excessively accommodating child-rearing style-unconsciously foster dependency so that the child can be indebted to the parents for life and must return the obligation as caregivers of the parents' old age. Life is a circular process vs. Western life is a lineal process, one does not look back.

Family is an obligatory system. "You owe me" and "No question asked"
-Parents do everything for the children in hoping that the children will fully invested their time and energy into school and achievement

in order to make the parents proud—Conditional love create anger and resentment, you don't love me, you love you and I am a condition to fulfill your selfhood or an instrument for your own self-love.
-One does not achieve maturity or leave home until marriage.

Intergenerational system serves structural system to decrease ambiguity, role function to smooth the social engine, elders solve conflicts for younger, however, it tends to be bias.

Family is patrilineal. Male-serving

Implications of Mental Health for Immigrants

1. Acculturation
   - Increasing language proficiency
   - Returning to school or retraining new job skills
   - Finding meaning for losses and suffering
   - Establishing a bicultural identity: embracing both heritages and avoiding polarization.
   - Being proud of the new identity and internalizing both realities

2.Uniting binary opposites by recognizing the values in both:
   - Applying concept of the Middle Path
     -Independence/Interdependence
     -Materialism/Spiritualism
     -Individualism/Collectivism
     -Self-responsibility/Family integrity
     -Competition/Harmony
     -Confrontation/Avoidance
     -Punctuality/Plasticity
     -Self/No-self

3.Practicing universal applicability or developing mental dexterity and flexibility

Culturally Relevant Counseling for Immigrants

I. Applications from Buddhism
   1. Mental flexibility-concept of water vs. rigidity of rock
   2. Suffering is inevitable vs. bad luck
   3. Self-responsibility or concept of karma vs. external locus of control or superstition
   4. Impermanence vs. past-fixation
   5. No-Self vs. narcissistic fulfillment
   6. Infinite life and death cycle vs. bereavement
   7. Compassion and wisdom vs. selfishness and ignorance
   8. Mindfulness vs. chaos and stress

II. Applications from Christianity
   1. Spiritual meaning for suffering or honor of "carrying the cross"
   2. Life mission or God's designated work on earth
   3. Compensation in deathless land or infinite after-life reward
   4. Purify one's soul for the meeting with God

ACCULTURATION LEVELS*

1. TRADITIONALISM: Withdrawing and seeking refuge in one's own culture due to loss, fear, and incompetence.

2. MARGINALISM: poorly adjusting to conflicting values and unable to meet the demand of both cultures which results in somatization and psychological problems

3. ETHNOCENTRICISM: A defense mechanism—over-idealizing of one's culture for self-protection and political strength.

4. ASSIMILATOR: Abandoning birth culture and former identity to completely embrace values in the host culture. Self-hatred and psychological problems can result.

5. BICULTURALISM: Integrating of values and belief systems from both worlds; achieving freedom from social bondage and cultural boundaries; practicing universal applicability.

*Adopted and modified from the research of Lin, K.M., Matsuda, M., & Tazuma, L. (1982). Hanh Vo M.Ed, LPC

Cultural Competency Toolkit

CHAPTER 9

The Campaign to Increase Cultural Competence

The Mental Health Association in Utah
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Mack Gift, Ph.D., Project Director

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Executive Summary

Utah's population is growing and becoming increasingly diverse; out of a total 1,916,000 inhabitants, some 203,000 individuals are minority persons. The Mental Health Association in Utah (MHAU) proposed to organize a training for one hundred mental health practitioners to meet and to learn about competently serving the state's various minority communities.

Project Goals

- To train 100 mental health professionals in cultural competency.
- To promote the training through an extensive media campaign.
- To develop recruitment and evaluation materials.
- To provide information on the training on MHAU's website.

Introduction

Utah's population is growing and becoming more diverse. As of May 1996, according to the Utah Department of Employment Security, there were a total of 203,266 minority persons out of a population of 1,916,000. Of these, 14,254 were African Americans, 27,058 were Native Americans, 45,371 were Asian Americans/Pacific Islanders, and 116,583 were Hispanic/Latino. And at least 29,000 people from various minority groups in Utah have serious mental illness.

As Utah's population becomes more diverse, the need for appropriate mental health services grows as well. Currently, there are not nearly enough culturally trained therapists, and without direct intervention this gap will only widen. At the time of this grant proposal, no public or private entity in Utah was providing in-depth, specific, multi-cultural training for mental health professionals.

No public or private entity in Utah was providing in-depth, specific, multi-cultural training for mental health professionals.

Program Plan

It is critical for public and private agencies to be staffed with culturally competent and appropriately qualified personnel, and it is consequently necessary for direct care staff to receive multi-cultural training. To see that Utah's growing minority populations were better served, MHAU proposed to organized a conference where 100 mental health professionals could meet to learn about working with minority populations. Conference presenters would be representatives of all of Utah's racial and ethnic groups.

Organizational Overview

MHAU was well-suited to carry out the proposed training. In Utah, there are five offices of Racial and Ethnic Affairs at the state level, and MHAU has worked with all of the executive directors of these offices to provide educational programs on mental illness. Additionally, MHAU has representation on the State Board of Mental Health, the Children's Mental Health Advisory Board, and the Chamber of Commerce.

MHAU staff and board members are also experienced in multi-cultural initiatives. Dr. Mack Gift, the project director and CEO of MHAU, wrote the curriculum for a community college for Native Americans and designed, implemented and directed "Project Respect," a self-help training program for inner city youth. Additionally, one of MHAU's board members serves as the Director of the Division of Indian Affairs for the State of Utah.

Dr. Mack Gift, the project director and CEO of MHAU, wrote the curriculum for a community college for Native Americans.

MHAU operates with a twelve member board composed of people strategically placed within the Salt Lake City community. Business professionals, mental health professionals, consumers, and widely known public personalities make up this board.

Implementation

As a first step to organizing the Conference on Cultural Competency, Gift established a planning committee with representatives from the different mental health provider organizations in Utah. The main purpose of this committee, according to Gift, was "to get commitment from these big providers that they would be supportive of the conference."

The committee met throughout June and July and assisted both in recruiting speakers for the conference and in publicizing the conference to mental health professionals. In September, flyers and brochures announcing the conference were sent out to all of the major mental health providers in the state and to twelve different treatment centers. Gift personally spoke with the directors of these centers to make sure that they encouraged their staff to attend.

MHAU aimed to find representatives from all of Utah's ethnic minorities to speak at the Cultural Competency Training Conference.

The conference was also published on MHAU's website with great success. Gift reports that the site received some 10,000 hits once details of the conference were posted.

MHAU aimed to find representatives from all of Utah's ethnic minorities to speak at the Cultural Competency Training Conference, and this goal was achieved. Keynote speakers included Native Americans, a Hispanic American, an African American, a Pacific Islander and an Asian American — all individuals with previous experience in offering cultural competency trainings. Additionally, Gift was able to recruit experts in Deaf culture and in interpreting.

Interest in the conference was much higher than expected, with 200 professionals from across the state registering to attend. Consequently, Gift offered the program on two consecutive weekends so that all interested individuals could take part.

Discussion and Conclusion

Clearly, MHAU's Cultural Competency Training was a remarkable success, with double the amount of mental health professionals attending as anticipated. Even though NCSTAC funding will not continue beyond this grant cycle, Gift is already making plans to offer a similar program next Fall. A local HMO, InterMountain Health Care, provided a generous grant for the 2000 conference and has already expressed an interest in providing further assistance for the 2001 conference.

"Make contact with persons of different racial and ethnic groups; become friends with the key players."
— Dr. Mack Gift, project director

Gift's advice for those interested in organizing similar programs is "to make contact with persons of different racial and ethnic groups; become friends with the key players." It was primarily through his personal contacts that Gift was able to recruit so many talented speakers to present at the conference.

Furthermore, MHAU made the conference particularly desirable to attend by providing continuing education credits to attendants. This option was arranged with the Continuing Education Committee of the National Association of Social Workers' Utah Chapter.

Additional Resources

(African Americans)

Byrd, W. Michael and Clayton, Linda A. *An American Health Dilemma, Volume One: A Medical History of African Americans and the Problem of Race: Beginnings to 1900.* New York: Routledge. 2000.

Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (Available on the internet at www.samhsa.gov/centers/cmhs/cmhs.html)

Pouissaint, Alvin and Alexander, Amy. *Lay My Burden Down: Unraveling Suicide and the Mental Health Crisis among African-Americans.* Boston: Beacon Press. 2000.

(Asian Americans)

Takaki, Ronald. *Strangers from a Different Shore: A History of Asian Americans.* Boston: Little, Brown. 1998.

Tuan, Mia. *Forever Foreigners or Honorary Whites?: The Asian Ethnic Experience Today.* New Brunswick, New Jersey: Rutgers University Press. 1998.

Uba, Laura. *Asian Americans: Personality Patterns, Identity, and Mental Health*. New York: Guilford Press. 1994.

Zia, Helen. *Asian American Dreams: The Emergence of an American People*. New York: Farrar, Straus, and Giroux. 2000.

(Deaf Culture)

Lane, Harlan. *When the Mind Hears: A History of the Deaf*. New York: Vintage Books. 1989.

Padden, Carol and Humphries, Tom. *Deaf in America: Voices from a Culture*. Cambridge, Massachusetts: Harvard University Press. 1988.

(Hispanic/Latino Americans)

Augenbraum, Harold et al. *Growing Up Latino: Memoirs and Stories*. Boston: Houghton Mifflin. 1993.

Garcia, Jorge and Zea, Maria (editors). *Psychological Interventions and Research With Latino Populations*. Boston: Allyn and Bacon. 1997.

Olmos, Edward (editor). *Americanos: Latino Life in the United States*. Boston: Little, Brown. 1999.

Padilla, Felix. *Latino Ethnic Consciousness: The Case of Mexican Americans and Puerto Ricans in Chicago*. Notre Dame, Indiana: University of Notre Dame Press. 1985.

(Native Americans)

French, Laurence Armand. *Counseling American Indians*. Lanham, Maryland: University Press of America. 1997.

Kelso, Dianne. *Bibliography of North American Indian Mental Health*. Westport, Connecticut: Greenwood Press. 1981.

Narduzzi, James. *Mental Health Among Elderly Native Americans (Garland Studies on the Elderly in America)*. New York: Garland Publishers. 1994.

O'Nell, Theresa. *Disciplined Hearts: History, Identity, and Depression in an American Indian Community*. Berkeley, California: University of California Press. 1996.

MHAU Mission Statement

The Mental Health Association in Utah promotes and supports mental health and advocates to improve the care and treatment of persons with mental illness through public policy and public education.

SPECIAL THANKS

Our appreciation is extended to *Intermountain Health Care* for a special grant to support this training conference

Additional recognition is extended to the *National Mental Health Association* for their support as part of the Campaign for America's Mental Health

Cultural Competency Training Conference for Mental Health Professionals

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Schedule

Friday, September 22
and
Friday, September 29

7:45 am to 3:15 pm

Sheraton City Center
(formerly Salt Lake Hilton)

150 West 500 South
Salt Lake City

7:45 am to 8:30 am (9-22 & 9-29)
Registration and continental breakfast

8:30 am to 9:30 am (9-22 & 9-29)
Keynote speaker: Forrest Cuch, Director, Utah Division of Indian Affairs
Topic: Cultural Competency and American Indians (Native Americans)

Breakout sessions:
Choose one for morning and one for afternoon

9:45-11:30 and 1:15-2:45 (9-22 & 9-29)

1. Jose Meza, M.S.W., L.C.S.W.
   Valley Mental Health

Topic: Engaging the family male perpetrator in therapy through the understanding of: "The Cultural Conceptual Origins of Machismo" Chicano, Hispanic, Latino

9:45-11:30 and 1:15-2:45 (9-22 & 9-29)

2. Herman Hooten, M.S.W.,
   Weber State University

Topic: Background history of African Americans in Utah. Mental health needs of the African American population in Utah, "barriers" to obtaining mental health services, and solutions to suggested problems.
(African Americans)

9:45-11:30 and 1:15-2:45 (9-22 & 9-29)

3. George Tonga,
   Salt Lake County Sheriff's Dept.

Topic: Diversity in the workplace today, an advantage - not a problem. A fun session.
(Pacific Islanders)

1:15-2:45 (9-22 & 9-29)

4. Fan Kwan,
   Valley Mental Health

Topic: Fact & fiction about refugees and immigrants from Asian countries. How to approach others in a culturally effective way.
(Asian Americans)

9:45-11:30 (9-22 only)

5. Rusty Wales, M.A.,
   Utah Div. of Services for the Deaf and Hard of Hearing

Topic: Understanding the Deaf Culture
(Deaf Culture)

9:45-11:30 (9-29 only)

6. Nino Reyos, M.S.W.

Topic: How to work with and understand Native Americans in the mental health field, including interview techniques
(Native Americans)

Luncheon speaker: 12:30-1:00 (9-22 & 9-29)

Ming Wang
State Division of Mental Health

Topic: Assist service providers in gaining the knowledge and skills to work effectively with interpreters in a mental health setting, including ethical issues and relationships.
(Interpreters)

Wrap up: 2:55-3:15 (9-22 & 9-29)

Mack Gift, Ph.D., Executive Director, Mental Health Association in Utah
Review and feedback about the conference

Agenda for Cultural Competency Training Conference

Friday, September 22 and Friday, September 29
Sheraton City Center (formerly Salt Lake Hilton)

7:45 am to 8:30 am		Registration and continental breakfast	
8:30 am to 9:30 am		Keynote speaker: Forrest Cuch, Director, Utah Division of Indian Affairs Topic: Cultural Competency and American Indians	(Native Americans)
9:45 am to 11:30 and 1:15 pm to 2:45 pm		Breakout sessions:	
9:45-11:30 (9-22 & 9-29) 1:15-2:45	1.	Jose Meza, M.S.W., L.C.S.W. Valley Mental Health Topic: Engaging the family male perpetrator in therapy through the an understanding of: "The Cultural Conceptual Origins of Machismo"	(Hispanic, Chicano, Latino)
9:45-11:30 (9-22 & 9-29) 1:15-2:45	2.	Herman Hooten, M.S.W., Weber State University Topic: Background history of African Americans in Utah. Mental health needs of the African American population in Utah, "barriers" to obtaining mental health services, and solutions to suggested problems.	(African Americans)
9:45-11:30 (9-22 & 9-29) 1:15-2:45	3.	George Tonga, Salt Lake County Sheriff's Department Topic: Diversity in the workplace today, an advantage - not a problem.	(Pacific Islanders)
1:15-2:45 (9-22 & 9-29)	4.	Fan Kwan, Valley Mental Health Topic: Fact & fiction about refugees and immigrants from Asian countries. How to approach others in a culturally effective way.	(Asian Americans)
9:45-11:30 (9-22 only)	5.	Rusty Wales, M.A., Utah Div. of Services for the Deaf and Hard of Hearing Topic: Understanding the Deaf Culture.(Deaf Culture, Doing it the Deaf Way).	(Deaf Culture)
9:45-11:30 (9-29 only)	6.	Nino Reyos, M.S.W. Topic: How to work with and understand Native Americans in the mental health field, including interview techniques	(Native Americans)
Lunch speaker: 12:30-1:00 (9-22 & 9-29)	7.	Ming Wang, State Division of Mental Health Topic: Assist service providers in gaining the knowledge and skills in working effectively with interpreters in a mental health setting, including ethical issues and relationships.	(Interpreters)
Wrap up: 2:55-3:15 (9-22 & 9-29)	8.	Mack Gift, Ph.D., Executive Director, Mental Health Association in Utah Review and feedback about the conference	

The Unified Voice

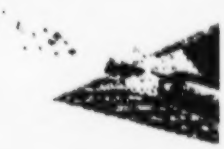
Mental Health Association in Utah

455 East 400 South, Suite 206, Salt Lake City, Utah 84111-3040.

November, December, 2000

Phone 596-3705 Email: mhaut@xmission.com

Fax 596-3658 Website: http://www.xmission.com/~mhaut/



Thanksgiving and Christmas
Joy, Renewal and Hope!

Conference on Cultural Competency

On September 22, 29 MHAU held two Cultural Competency Training Conferences at the downtown Sheraton. The conferences were well attended and according to the evaluations were overwhelmingly successful. Over 200 mental health professionals attended and heard some of the finest local authorities speak on topics which are extremely pertinent to providing consumers with effective counseling procedures.

A warm thank you goes to Jose Meza and Fan Kwan of Valley Mental Health. Forrest Cuch, Director of the State Division of Indian Affairs. Herman Hooten from Weber State University. Ming Wang from the State Division of Mental Health. George Tonga from the County Sheriffs Office, Ninos Reyes from Discovery House and Rusty Wales from The Utah Division of Services for the Deaf and Hard of Hearing. All of these people gave excellent presentations and deserve enormous credit.

October 5th was National Depression Screening Day.

Each year, The National Mental Health Association as well as The American Psychiatric Association, The National Institute of Mental Health, McLean Hospital, The National Alliance for the Mentally Ill, The National Association of Psychiatric Health Systems and The National Depressive and Manic-Depressive Association sponsor this event.

SOCIAL WORK CONTINUING EDUCATION SPONSORSHIP APPROVAL

SEND WITH CHECK TO:	***DO NOT WRITE IN THIS SPACE***
Utah Chapter, NASW Continuing Education Committee U of U, GSSW #229 395 South 1500 East Salt Lake City, UT 84112-0260	**CK#_____ RECEIVED $_____** **DATE APPROVED:_____** **CATEGORY:** 1. **Courses, seminars, lectures, conferences, or training sessions** 2. **Continuing Education Teaching** (clinical social work or mental health therapy) **NOTIFICATION SENT_____** **CONFIRMATION # _____**

1. Sponsoring Agencies and/or organizations

_____
_____

2. Mailing address:

Name_____
Street_____
City_____ State_____ ZIP_____
Telephone_____ Fax_____

3. Name and Title of individual submitting application for approval (state address if different from above)

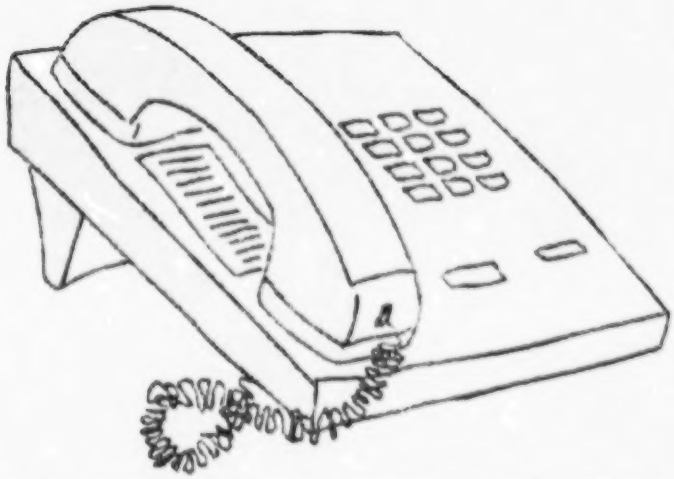
Name_____
Street_____
City_____ State_____ ZIP_____
Telephone_____ Fax_____

Name/address/phone of **individual to receive confirmation** if different from above

Name_____
Street_____
City_____ State_____ ZIP_____
Telephone_____ Fax_____

Cultural Competency Toolkit

CHAPTER **10**



Implementing a Multi-Lingual Warm-Line

Consumer Voices Are Born
3303-B N.E. 44th Street
Vancouver, Washington 98663
Tel. (360) 695-5012
Fax. (360) 993-1166

Donna Roberts, Project Director

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Executive Summary

Consumer Voices Are Born (CVAB), a consumer-run drop-in center, proposed to establish a warm-line where individuals in the Clark County, Washington area facing mental health challenges could call in and discuss their problems with a peer. These consumer volunteers would be trained by crisis personnel and would be able either simply to listen or to make referrals to crisis or other community sources as needed. Additionally, CVAB proposed to recruit individuals representative of Clark County's multi-ethnic communities and to publicize the warm-line throughout these various communities.

Project Goals

- To set up phone and pager systems for a multi-cultural warm-line.
- To recruit and train consumer volunteers to staff warm-line.
- To network with service providers conducting minority outreach.
- To translate materials into appropriate languages.
- To advertise and promote warm-line.

Introduction

At the time of this grant proposal, Clark County, Washington had a county-wide crisis response plan to address the needs of people in acute psychological crisis. Under this system, people in crisis could be assessed by professionals and referred for hospitalization. There were no intermediate services available, however, for people simply to talk and de-escalate. Local consumers could not meet with a crisis worker simply to talk, or to focus on problems that, while not acute, could potentially escalate through lack of attention.

If any such new services were to be established, it was also important that they take into account Clark County's multi-ethnic makeup. In recent years, significant numbers of Russian families had settled in the area, as well as South East Asian immigrants and people of Hispanic/Latino descent. Many of these populations were quite insular, and their members faced a cultural isolation which could only make more difficult the burden posed by mental illness.

Many of Clark County's ethnic populations were quite insular, and their members faced a cultural isolation which could only make more difficult the burden posed by mental illness.

Program Plan

CVAB proposed to establish a warm-line where members of the Clark County community could call in and discuss their problems with a peer. These peer volunteers would be trained by crisis personnel and would be able either simply to listen or to make referrals to crisis or other community sources as needed.

Служба **WARM LINE** под эгидой CVAB
Не с кем поговорить?
Все не так?
ЗВОНИТЕ НА ПЕЙДЖЕР:
(360) 750-2012 или (360) 750-2014
вторник — суббота с 12.00 до 22.00
Мы реагируем незамедлительно!

Warm Line notice in Russian.

The warm-line would be staffed by mental health consumers representative of Clark County's multi-ethnic population. By networking with other service providers already conducting minority outreach, CVAB would publicize the warm-line throughout these various communities. And information materials on the warm-line would be made available in different languages.

Organizational Overview

Consumer Voices Are Born (CVAB) is an organization made up of consumers for consumers serving the Clark County, Washington area. A 501(c)(3) entity, it receives support from the Clark County Mental Health Community. At the time of this grant request, CVAB was already managing an entirely consumer-operated drop-in center.

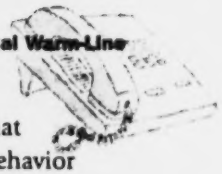
Consumer Voices Are Born is an organization made up of consumers for consumers serving the Clark County, Washington area.

CVAB is recognized by its various partners within the mental health community as an independent, yet integral part of the community. CVAB board members provide regular feedback to the community regarding quality of care and consumer needs. The Clark County Regional Support Network, which is the governmental agency that manages the county's Medicaid mental health dollars, has long supported CVAB and has encouraged its growth. CVAB also works closely with the county mental health authority and with the private managed care association, United Behavioral Health.

Implementation

In March, 2000, CVAB entered into an agreement with a group of county-designated mental health professionals, the Columbia River Mental Health Services crisis team, to provide warm-line training to consumer volunteers. Columbia River then offered two, day-long trainings in 2000 to altogether twenty individuals.

The trainings were rigorous and thorough. Participants learned about symptomology, or the ways that individuals may behave when they are experiencing certain symptoms. Workshop leaders reviewed the differences between a warm-line call and a crisis call, and discussed under what circumstances it is appropriate for warm-line volunteers to contact crisis



services. Participants also learned how to take "DAP" notes, a form of charting that provides a description of what the caller is saying; an assessment of the caller's behavior and emotional state; and an action plan that the caller and warm-line volunteer agree upon together.

Important time during the trainings was also devoted to how the volunteers should prepare and protect themselves emotionally when taking calls. Issues of boundaries and self-care were discussed.

Monthly training topics could cover how to help someone who was hearing voices or simply how to assist someone in finding the right doctor.

Once warm-line volunteers had completed a day-long training, CVAB followed up with ongoing, monthly training sessions to help the volunteers further develop their skills. Monthly training topics could cover how to help someone who was hearing voices, how to connect an individual with appropriate faith-based services in the community, or simply how to help someone to find the right doctor.

Additionally, CVAB offered separate cultural competency trainings. According to Donna Roberts, the project director, these detailed trainings focused "not just on ethnic diversity, but also on understanding diversity within a particular community. For example, there may be two people who are both from Russia, but one comes over because he wants to go to school in the United States, and the other comes as a refugee... They will have two very different approaches."

Minority outreach

CVAB was able to provide assistance to individuals in a variety of languages. Warm-line volunteers included Native Americans, Russian speakers, Spanish speakers and one Laoatian speaker. In addition, a sign interpreter was available for non-hearing individuals who wished to visit the facilities for assistance. Roberts reports, "we never had a problem of someone calling and not having a volunteer who knew their language."

Roberts conducted extensive public outreach to the Clark County's various ethnic communities, meeting with community leaders and attending community functions to provide information on the warm-line. She describes these public outreach efforts as "absolutely necessary and ongoing." In addition, CVAB prepared translations of their informational brochures in Cambodian, Russian, Vietnamese, Laotian and Spanish.

Translation services can be the most expensive part of a multi-lingual operation. Translating one brochure can cost several thousand dollars.

To find translators, Roberts spoke with several public offices that she knew, by law, were required to provide translations of their written materials, and she asked them to recommend translators. She was also able to gather some translated materials for free this way: "Some of the documentation — like our complaint and grievance policy — is the same one used by the county regional support network, so I received copies from them."

Warm-line staffing/ usage

The number of calls the warm-line received could vary, with peak volume reaching some two hundred calls per month. Calls could also be lengthy, and Roberts reports that "on the average people will call and talk from 30 to 90 minutes." She adds, "we have had calls that have been six hours in length."

CVAB rented two pagers per month with voice mail for $15.00 each. Each pager could handle 500 calls per month.

To meet this demand, CVAB relied upon a group of twenty volunteers. For the day shift, typically CVAB tried to have two volunteers available at all times to field calls, with a supervisor also present. At night, they also tried to have two individuals available, but sometimes it was necessary to have one person handle both pagers—with a back-up person available to take extra call as needed.

CVAB received all calls through a system of two pagers with voice mail. Incoming calls went directly to the pager and were then answered typically within ten seconds. The longest a call-back might ever take was six minutes.

To make the warm-line known throughout Clark County, Donna Roberts, project director, relied on her connections with various minority community leaders.

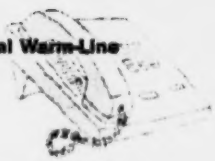
Discussion

In conducting minority outreach, "most of the work I have done has not been in publicizing the warm line," says Roberts. "It has been in getting someone to introduce me into the community's inner circle, and then letting them get to know me and trust me." To make the warm-line known throughout Clark County, Roberts relied on her connections with various minority community leaders.

For example, Roberts met a South East Asian woman through the YMCA who was a recognized leader in that community. Says Robert, "I spoke with her when we first started the warm-line. Then I kept her posted about our progress along the way, and I gave our translated materials to her." Ultimately, the community leader invited Roberts to attend a conference on South East Asians in America held in Clark County.

With the Russian community, Roberts went through a similar process. Through her work on the county's mental health cultural competency committee, Roberts met a Russian-American woman who worked with a local managed care provider. This woman then provided Roberts with further introductions into the local Russian community.

Making these inroads, according to Roberts, requires time and patience. "Once you have made the contact with the local leaders, then they will ask you more about your program and then they'll go back and let their community know. So it's a long a process."



Providing a safe venue

Roberts does feel that the warm-line offers a venue for individuals who might be hesitant to seek help in other forms. For example, "especially in the South East Asian community, it is still not widely accepted to go outside of the family unit for help — and if you do, you go to a community elder or a spiritual leader rather than to the mental system. We offer some anonymity that you won't find in going into a mental health organization."

Moreover, the fact that the warm-line is run by consumers may also make it easier for people in need to pick up the phone and ask for help. "We also offer a little more because we're not professionals, we're peers. So there's not the same stigma that's entailed in going to a professional."

"Once you have made the contact with the local leaders, then they will ask you more about your program and then they'll go back and let their community know. So it's a long a process."

—Donna Roberts, project director

Finally, Roberts adds, "and one of the other things that we try to do because what's accepted in our (predominantly Caucasian) culture is not necessarily accepted in other cultures, is we try and team a male and a female so that people can speak to the gender they're more comfortable with."

Conclusion

CVAB's warm-line has been such a success that in April 2000 the Clark County Board of Commissioners and the Mental Health Advisory Board adopted CVAB as a formal entity in the Clark County Crisis System. *The Oregonian* and *The Columbian*, local newspapers, have both run articles reporting on the warm-line, and Roberts has also been interviewed by the local cable television news channel.

The Oregonian and The Columbian, local newspapers, have both run articles reporting on the warm-line.

With this interest and support, the warm-line will continue to grow. As of this writing, Roberts has 22 new consumer volunteers awaiting warm-line training, and she has hopes of eventually making services available 24 hours a day, seven days a week.

Roberts would like also to serve as an example to mental health organizations interested in launching similar initiatives. "I'd like to see us partner with other places across the state that are trying to get their own programs going." She has already received queries from different organizations, including one as far away as Wichita, Kansas.

Most importantly, Roberts wants warm-line services to continue to penetrate into Clark County's various minority communities. She sees continued growth and outreach in this direction as "absolutely necessary... We just got the census back. The Hispanic community has more than doubled and there have been significant rises in the rest of the minority communities as well." With continued effort and planning, CVAB should be well-placed to meet these growing needs.

Additional Resources

WARM LINE của CVAB

Hỡi những người hưởng dịch vụ, quý vị có cần nói chuyện với ai không?
Có phải quý vị đang có những khó khăn đang xảy ra chăng?
NẾU CÓ HÃY NHẤN (PAGE) CHO CHÚNG TÔI Ô SỐ:
(360) 750-2012 hoặc (360) 750-2014
Thứ Ba – Thứ Bảy; 12 GIỜ TRƯA – 10:00 GIỜ TỐI
Chúng tôi sẽ gọi lại cho quý vị ngay!

Warm Line notice in Vietnamese.

(Asian Americans)

Takaki, Ronald. *Strangers from a Different Shore: A History of Asian Americans.* Boston: Little, Brown.1998.

Tuan, Mia. *Forever Foreigners or Honorary Whites?: The Asian Ethnic Experience Today.* New Brunswick, New Jersey: Rutgers University Press. 1998.

Uba, Laura. *Asian Americans: Personality Patterns, Identity, and Mental Health.* New York: Guilford Press. 1994.

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(Hispanic/Latino Americans)

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Olmos, Edward (editor). *Americanos: Latino Life in the United States.* Boston: Little, Brown. 1999.

Padilla, Felix. *Latino Ethnic Consciousness: The Case of Mexican Americans and Puerto Ricans in Chicago.* Notre Dame, Indiana: University of Notre Dame Press.1985.

(Russian Americans)

Berry, Ellen E. and Epshtein, Mikhail N. *Transcultural Experiments: Russian and American Models of Creative Communication.* New York: St. Martin's Press. 1999.

Foner, Nancy (editor). *From the Workers' State to the Golden State: Jews from the Former Soviet Union in California.* Boston: Allyn and Bacon. 1995.

Govorchin, Gerald Gilbert. *From Russia to America With Love: A Study of the Russian Immigrants in the United States.*

LETTER OF UNDERSTANDING
BETWEEN
CRMH CRISIS SERVICES
AND CONSUMER VOICES ARE BORN (CVAB)

This letter of understanding establishes the agreement between Crisis Services and CVAB, for training and debriefing of Warm Line personnel. The time period for this agreement is March 1, 2000 through March 1, 2001.

Now therefore the parties agree as follows:

1. Crisis Services will provide CVAB Warm Line personnel with their initial Training to include:
   a) Assessment
   b) Management
   c) Planning
   d) Follow-up

2. Crisis Services will provide ongoing training on a quarterly basis as needed.

3. Crisis Services will provide debriefing to Warm Line personnel on a case by case basis as needed.

4. The parties acknowledge that they have agreed to and understand this agreement, and do agree there to in every particular. This agreement may be modified or amended in writing with the mutual consent of all parties. The parties further agree that this agreement supersedes all communication, written or oral, heretofore related to the subject matter of this agreement. Unless preceded by a thirty (30) day prior written notice this agreement shall terminate March 1, 2001.

5. This agreement has been and shall be construed as having been executed and delivered within the State of Washington, and it is agreed that this agreement shall be governed by the laws of the State of Washington, both as to interpretation and performance.

Consumer Voices Are Born	CRMH CRISIS SERVICES
Donna Roberts	Marva McGrath
Signature	Signature
8 March 00	3/07/2000
Date	Date
Donna Roberts	Marva McGrath
Printed Name	Printed Name

1

TO: Warm Line Applicant

FROM: CVAB

SUBJECT: Warm Line Volunteer Training

Thank you for your interest in staffing the CVAB Warm Line. We are pleased to provide you with an application. There are several steps involved in the application process.

1) The first step is to complete the required paper work and return it to the CVAB offices at 3303-B NE 44th Street, Vancouver, WA 98663.
2) There will be a background and reference check of all applicants (which is to protect you and all others involved). After all of the background and reference checks have been returned, you will participate in an interview.
3) If at that time you are accepted for the training, a training agenda and a manual will be will provided to you.
4) You will be trained by Crisis Line personnel, and then, you will be approved for volunteering on the CVAB Warm Line.

Volunteers for the CVAB Warm Line are providing a much-needed service to our community. That is, helping fellow consumers of mental health services get through difficult times. The CVAB Warm Line is a fine example of our motto, "Be Not Alone". Volunteers must be caring, dedicated, knowledgeable, and reliable.

This is a good opportunity to make a difference in someone's life.

If you have any questions about the application process, please contact us at the CVAB office at 3303-B NE 44th Street, in Vancouver, our phone Number is (360) 695-5012 and we will be there from 9am to 5pm.

CVAB reserves the right to reject any applicant at its sole discretion.

All of us at CVAB would like to Thank You for your time.

CVAB WARM LINE
POSITION DESCRIPTION

JOB TITLE: CVAB Warm Line Volunteer

DESCRIPTION & PURPOSE

The CVAB Warm Line is a telephone support system for consumers of mental health services. Consumers call to talk to someone who understands and can provide support and encouragement. The job of a trained Warm Line volunteer is to carry a pager and answer pages from consumers promptly in order to prevent a potential crisis. Volunteers are not crisis workers and are not trained for or expected to respond to crisis situations. Volunteers also provide information and referral to appropriate services as needed.

RESPONSIBILITIES & DUTIES

- Attend initial and on-going training.
- Provide information about possible resources to callers as needed.
- Collect important information about the caller as per the form provided for each call.
- Be available for shifts to cover the pager as assigned.
- Provide an attitude of understanding and acceptance to the callers.
- Listen objectively, nonjudgementally and with compassion so that the caller feels heard and respected.
- Submit regular activity reports.

SUPERVISION

The president or someone appointed by the president of CVAB will supervise routine activities and responsibilities of the Warm Line volunteers. Final authority over the Warm Line rests with the president of CVAB.

EVALUATION

Volunteer Warm Line staff are evaluated on job performance by the president of CVAB, or someone appointed by the president of CVAB, three months after their first day of work on the Warm Line and annually thereafter. Annual recertification will be based on satisfactory performance reports.

REQUIREMENTS

- The volunteer must be a mental health consumer.
- A sincere interest in listening to and responding to consumers who need someone to talk to.
- A working phone, or regular access to one, so that you can return the call quickly to people who page you for help.
- The ability to work well with other volunteer staff, mental health professionals and CVAB members as well as the callers themselves.
- Successful completion of the training program.
- Commitment to provide at least one shift per week of volunteer pager coverage. Additionally, a commitment to participate in the CVAB Warm Line for six months.
- Go through a debriefing process weekly and as needed or provided.

RESTRICTIONS

- A volunteer must be at least 18 years old.
- A volunteer must pass the Washington State Patrol Background Inquiry Application.
- A volunteer shall not use this position for any financial benefit, direct, indirect or implied.
- A volunteer shall not conduct or engage in political or religious activities during any conversations with callers.

CONSUMER VOICES ARE BORN
WARM LINE VOLUNTEER APPLICATION

Name: _____ Telephone: _____
Address: _____
_____
_____

Date of Birth: _____ Sex: M____F____
Emergency contact person: _____ Phone:_____
Relationship: _____

Please describe why you want to volunteer for the Warm Line.

_____
_____
_____
_____
_____

Please tell us what your experience with mental health services has been:

_____
_____
_____
_____
_____

How will your experience with mental health services assist you in volunteering for the Warm Line?

_____
_____
_____
_____
_____

Volunteer experience:
Are you presently a volunteer? _____ Yes _____ No
Have you had previous experience as a volunteer? _____ Yes _____ No
If so, list organizations and type of work: _____
_____
_____
Do you speak languages other than English? (specify) _____

Availability:
Are you willing to volunteer a minimum of five hours per week? ____ Yes ____ No
Are you available: Afternoons? _____ Evenings? _____

References: (therapist and/or casemanager)
Name Address Phone No.

_____
_____
_____

A police record check is required for all volunteers and staff.

Will you give permission for this check? _____Yes _____No

If there is any other information you would like us to know, please list below:

_____
_____
_____
_____ _____
_____

CVAB reserves the right to accept or reject any applicant at its sole discretion.

_____ _____
Signature of Applicant Date

For Office Use only

Interviewer:_____ Title: _____
Date of Interview:_____ Applicant: [] Staff [] Volunteer
Position applying for: _____
Placement Recommendation: _____
If no placement at this time, please state reason: _____
_____
Comments: _____
_____
_____
_____
_____

CVAB
Reference check
Therapist or casemanager

To: Reference's Name: _____

Address: _____

Phone: _____
(Home) (Work)

Re: Staff/Volunteer Name: _____

Placement/Position: _____

1. How long have you known this person?

2. What are this person's strengths?

3. Do you know of any limitations that would affect this person's ability to work with a population of at risk adults and adolescents?

4. How would you describe this person's reliability?

5. Can you think of anything else that would be important to know about this person? If yes, please explain.

Signature: _____ Date: _____

Phone interviewer: _____ Date: _____

Please return completed form in envelope provided. Thank You.

If you need more space use back.

CVAB
Contract of Commitment

Requirements:

1. Time commitment of six months / 20-36 hours per month
2. Initial Warm Line training and three months of on site supervision.
3. Do either: a five or ten hour Warm Line shift per week.
4. Weekly debriefing.
5. Ongoing monthly trainings.

I agree to the above requirements, and am willing to make this commitment.

Signature: _____ Date: _____

Name: _____
(please print)

Witness: _____ Date: _____

Name: _____
(please print)

Confidentiality

As an employee, student, volunteer, or acting in any other capacity in connection with CVAB I agree to the following:

1. All charts, notes, and other written material concerning consumers will be maintained under lock and key when not in use. Diskettes containing client information will likewise be locked in a disk holder when not in use.

2. Discussions regarding consumers will be held in staff offices only.

3. Privileged information about consumers will only be discussed with authorized persons, ie; warm line supervisor, crisis, police or mental health contact.

4. For privileged information, written or verbal, to be shared with other agencies or professionals, written authorization must first be obtained from the consumer, except in emergency situations.

5. Access to consumer files is limited to warm line volunteers and support staff.

6. Strict confidentiality is to be maintained at all times, failure to do so will result in immediate dismissal from the Warm Line

_____ _____

Signature of Volunteer Date

_____

Printed Name of Volunteer

_____ _____

Signature of Warm Line Supervisor Date

_____

Printed Name of Warm Line Supervisor

WARM LINE PROCEDURES

(1) Shift schedules will be made up at the beginning of the month. Anyone who is going to be gone needs to give advance notice in writing to the WL supervisor so that the schedule can be adjusted to cover your shift.

(2) Be on time for your scheduled shift. It is the responsibility of the volunteer to notify the WL supervisor each day the volunteer will be absent from a regularly scheduled shift. Repeated tardiness, or lack of reporting, may result in termination.

(3) When reporting in for your shift, please sign in on the log sheet in the WL office and pick up your training notebook. All training notebooks are to be returned to the file cabinet at the end of your shift.

(4) All WL calls will be documented using the response logs found in your training notebooks. The volunteer's name must be printed in the appropriate place on all response logs.

(5) At the end of each shift all filled out response logs will be placed in a designated place.

(6) When a referral is made to crisis or to a therapist/case manager flag the response log so follow up can be done.

(7) If you have a problem with a call, ask for help or write down in your notebook what the problem was so we can address it at the weekly debriefings.

Warm Line Response Log

DATE ____/____/____

Time of Page _____ **am pm**

Returned Page _____ **am pm**

End of Call _____ **am pm**

_____
Volunteer Name

CALLER'S NAME: _____, **Age**_____, **M F**

Phone # _____

Address _____

_____

City _____

State _____, **Zip**_____

Services from: _____

Race: African_____, **Asian**_____

Hispanic____, **Native American**__

Caucasian___, **Russian**____.

Therapist / Case Manager: _____

Use DAP Charting:

D – Description
A – Assessment
P – Plan

Remember to sign your name at the *end* of your charting so no one can add to the chart! Thank you.

NOTES (If you need more room use back)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
Supervisor

BE CALM!

Kurt Kettwig 9/18/2000

CVAB WARM LINE
VOLUNTEER'S INFORMATION

BASIC PRINCIPLES TO REMEMBER

1. The volunteer's basic response needs to be grounded in a respectful, relational approach in which the client is offered:
   - RESPECT
   - INFORMATION
   - CONNECTION
   - HOPE

2. Steps to every assessment:
   - To assess the caller's three self-capacities:
     - feeling management skills
     - inner connection to others
     - overall sense of self-worth

   - To decide how you and the caller can work together to address the caller's problem in a constructive way, and to focus on their strengths

3. Four steps to help the caller separate their past from the present
   HELP THE CALLER:
   1) separate the past from the present (using grounding techniques)
   2) exercise control and choice
   3) stay connected or regain connection to others
   4) whenever possible, to recognize the connection between the past experiences and the present

HOW TO PROTECT YOURSELF

PREVENTION

AWARENESS: be attuned to your needs, limits, emotions and resources.

BALANCE: seek balance among life activities and within yourself.

CONNECTION: to others, to yourself and to something larger.

ADDRESSING

SELF-CARE:
- Find balance
- Reconnect with your body (e.g., exercise, massage)
- Set limits
- Practice healthy habits (e.g., sleep and eat)
- Make connection a priority
- Self- soothe

SELF- NURTURANCE:
- Seek gentleness
- Focus on pleasure and comfort
- Relax, Play and Laugh

WARM – LINE VOLUNTEER SCHEDULE

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
NOON – 5:00 PM	NOON – 5:00 PM	NOON – 5:00 PM	NOON – 5:00 PM	NOON – 5:00 PM	NOON – 10:00 PM	NOON – 10:00 PM
1. 2.	1. 2.	1. 2.	1. 2.	1. 2.	1.	1.
5:00 – 10:00 PM	5:00 – 10:00 PM	5:00 – 10:00 PM	5:00 – 10:00 PM	5:00 – 10:00 PM		
1. 2.	1. 2.	1. 2.	1. 2.	1. 2.		

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
NOON – 5:00 PM	NOON – 5:00 PM	NOON – 5:00 PM	NOON – 5:00 PM	NOON – 5:00 PM	NOON – 10:00 PM	NOON – 10:00 PM
1. 2.	1. 2.	1. 2.	1. 2.	1. 2.	1.	1.
5:00 – 10:00 PM	5:00 – 10:00 PM	5:00 – 10:00 PM	5:00 – 10:00 PM	5:00 – 10:00 PM		
1. 2.	1. 2.	1. 2.	1. 2.	1. 2.		

CVAB'S

WARM LINE

TRAINING MANUAL

Warm Line Training

Written by: Kurt Kettwig

Logistics – pagers, scheduling

Administrative – confidential, documentation, files, protocol, debriefing.

Clinical - #1) Assessment #2) Planning #3) Management #4) Follow-up

1. Assessment: Find out what the problem is, How can you help.
2. Planning: What would the caller want to do?
3. Management: You need to care about the caller. (Do the plan!)
4. Follow-up: Call the person to see how they are.

THINGS TO FIND OUT: Name, Phone number, Address, Age, Are they safe, Are they alone, Who is their provider

This information is important but, do not pressure the caller. Work these questions in during the conversation!

ALWAYS BE CALM!

BE RELIABLE AND CARING!

THE CALL: **Is it the callers need or is it something else?**

THE NUTS AND THE BOLTS OF THE WARM LINE

Keep a logbook with needed referrals and important phone numbers!

Start a file system of information for yourself!

A possible greeting – Hello my name is _____with the CVAB Warm Line is there anything I can help you with?

Remember to have a calm voice when talking to a caller.

Remember that time is on your side!

- Paraphrasing the caller: Repeat what they are saying.
  They need to be heard and understood
  Let them say what they need to say
  and/or let them vent.

- Reflection: Reflect what they are feeling.
  Make sure you have a sense of what they
  may be feeling and saying.

90% of what we'll be dealing with is FEELNGS!

- Validating Feelings: Understand what they are feeling.
  Identify with them
  If they are feeling guilty about what they
  are feeling, tell them that it is all right to
  have these feelings, it's only human.

- Identify feelings/issues: Use open ended questions to help identify Issues/feelings.
  Ask them what might have worked in the past?

BE OPEN TO THE CALLERS NEEDS!

Remember that time is on your side, never push the caller, it will back fire!

If the call pushes your buttons
give the call to another W.L. volunteer!!!

One thing to always remember---NEVER give "Permission" to do anything harmful to self or others!!

If they insist on harmful acts----Refer the call to CRISIS or call 911!

A – Always be caring!
B – When in doubt ask for help!
C – Let them know you understand!

Possible Situations You'll Come Across, And the things you should do.

SUICIDE:

#1 – Ask if they feel suicidal?
#2 – Were you thinking of acting out the thoughts?
#3 – What are you thinking of doing?

REFERAL:

#1 – Ask them if it is all right to hang up and have the Crisis Line call right back?

#2 – If they say no, ask if it would be all right if you can have a consultation?

#3 – If they hang up:

A) call 911!

B) If you call 911 they will need:

1) name of the caller
2) phone number of the caller
3) is there any weapons in the House
4) where are they in the house
5) are they alone

C) then call the crisis line (they will need the same information)!

HOMICIDAL:

#1 – Try to get them to slow down to interrupt the process!

#2 – Get some history.

#3 – Ask if they are hearing voices, if yes ask them what helps to lesson the voices?

#4 – Ask if they are planning to harm someone, then try to find out who and where?

#5 – Ask if they have taken their MEDS and/or if they had a MED change?

DOMESTIC VIOLENCE:

This will be a difficult call because; you will probably have to do most of the talking. Then you will have to ask a lot of questions because they can't say much.

Here are some things you might want to ask:

A) Do they want you to call 911?
B) Where is the other person?
C) Is the other person drinking or on drugs?
D) Tell them to get out of there if they can!
E) Help them with ideas like calling the YWCA, domestic violence hot line etc...

ALWAYS BE CARING AND CALM! TIME IS ON YOUR SIDE!

DEPRESSION:

#1 – Interrupt the process!

#2 – ask them what might have started it?

#3 – Ask what they did before to lesson the symptoms?

#4 – Let them know that you care about them! Be real with them.

#5 – Tell them that you have lots of time for them!

#6 – Ask if you can make a referral to the crisis line (CDMH) for them.

#7 – Ask if they have taken their meds or if they had a med change?

REMEMBER THAT TIME IS ON YOUR SIDE!

NEVER GIVE PERMISSION TO HARM!

BE CALM AT ALL TIMES!

BE CARING!

BE SAFE!

SOME KEYS TO PROTECT YOURSELF:

#1 – Show your work!

A) Use the Warm Line response log.

#2 – Take notes (use DAP charting)!

A) Use the Warm Line response log!

#3 – Remember to turn your response logs in to the W. L. supervisor!!!

#4 – Sign your name at the end of your charting!
9/18/009/18/00

ASK IF YOU NEED HELP!

WE ARE THERE FOR YOU AT ANYTIME!

GOOD JOB
AND
GOOD LUCK TO ALL OF YOU ON THE WARM LINE!!

Thank you for volunteering!